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Why don't we ask people what they need? Teaching and learning communication in healthcare

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Dedication

For my father

A working man who lived and died with such dignity

1923 – 1998

ABSTRACT

There are numerous empirically described problems of communication in healthcare. The doctor/patient relationship is fundamental to many such problems. The changing nature of healthcare and the doctor/patient relationship is explored in this thesis. An increasing evidence base demonstrates that patient outcomes in healthcare are directly related to clinical communication.

However, more fundamental than patient outcomes is the very nature of personhood and the effects illness has on individual autonomy. A theory of human need provides the foundation for discussion. Autonomy in healthcare is discussed in these terms and is argued as a basic human need.

Moreover, human communication is argued as a basic human need using the same theoretic approach. It therefore follows logically that health professionals have the same duties and responsibilities to meet basic human communication needs on the same terms as those for autonomy. The relationship between autonomy and communication is shown to be a reflexive one.

A theory of democratic communication is drawn on to describe the type of communication that will meet autonomy and communication needs. This is set in the context of healthcare. Consent in healthcare is used to show how far we have come in meeting communication and autonomy needs.

Given the argument so far it is reasonable to expect medical education to respond to the changing and recognised needs of the users of healthcare. The role of effective communication in medical education programmes is explored.

Finally, a strategic approach to organising and delivering a communication curriculum is proffered which tries to meet both the philosophically and democratically argued basic needs. The resulting communication curriculum combines theoretic foundations with a pragmatic approach to the problems of clinical practice.

If the approaches in this thesis are followed then communication can no longer be perceived as something doctors do after they have completed other medical tasks. Effective doctors have to be effective communicators in order to meet patients' needs.

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INTRODUCTION

WHY DON'T WE ASK PEOPLE WHAT THEY NEED?

The question in the title of this thesis will be shown to be significantly more complex than the face value simplicity of the question. The context of the question will be set in healthcare and the problems and barriers posed in trying to answer the question will be described and analysed. Four key themes will emerge throughout the development of the argument. First; the problems of communication in healthcare, second; the problems of defining human need and health needs and the use of a proposed theory of human need (Doyal and Gough 1991) and third; operationalising a communication theory that offers an approach to deal with the first two problems and emphasises consensus as a main aim of communication (Habermas 1981). Finally the role that health professional education has in meeting patients' communication and health needs will be explored.

Communication has long been recognised to be a problem in healthcare. Meta-analysis of nearly thirty years of research into patients' views and outcomes of communication in healthcare consistently showed a failure to meet the communication and information needs of patients, relatives and carers (Ley 1988). The doctor/patient relationship has been and continues to be the subject for sociological analysis (Parsons 1951, Balint 1957, Freidson 1970, Gerhardt 1987, Silverman 1987, Scambler 2001).

Historically, health services and medical education were developed in ways that primarily met the needs of the health care systems themselves as opposed to the needs of patients and users of healthcare provision. Descriptions of needs based services tended to be based in rhetoric rather than practice and reality (Harrison et al 1990, Klein 1983). These problems are compounded by disagreement over approaches to health needs. Debate about the relativity, objectivity or universality of needs has exercised political and social scientists (Townsend 1962, Wiggens 1985, Braybrooke 1987, Doyal and Gough 1991) over the years.

Doyal and Gough (1991) offer a theory of human need that defines health and autonomy as basic human needs and describe health care as the intermediate need that will demand need satisfaction in order to protect the basic need for health. They argue ill health is a threat to individual autonomy, as when people become ill their ability to participate in society and follow their chosen life path is threatened or reduced. In order to flourish as human beings we need to have our ability to participate in society maximised and anything that reduces our capacity to do so causes us serious harm.

Moreover, there has been a lack of consensus on the role and position that communication holds per se, and in the meeting of health needs. Taking Doyal and Goughs theoretic framework, communication can be argued as a basic human need along with health and autonomy. However, what type of communication will be most useful in meeting the needs of patients and why still demands critical thought. This could be, in part at least, why National Health Service reforms and developments in health professional education have been slow to have a significant

impact on patients and carers experience of communication in healthcare. In the dawn of a new century we have continuing problems with meeting healthcare users communication needs (Kennedy Report 2001).

Habermas (1981) argues in his theory of rational and democratic communication that there is a distinct analytical difference in integration into what he calls the system world (political, science and welfare state) and the lifeworld (less formally constructed and socially integrated by communicative action). His interpretation of the power that the system world, politicisation and scientisation of everyday life, has over the lifeworld is a dominant and essentially violent force that has taken the form of 'colonisation'. Moreover, communication becomes systemically distorted. The colonisation of the lifeworld thus prevents the symbolic reproduction of society through democratic, rational and socially integrated communicative acts. The resulting skewed modern society causes pathologies in the lifeworld, as consensus dependent communicative acts are repressed.

Healthcare, and medicine particularly, is the subject for Habermasian analysis. Two areas that can benefit from this approach are consensus and consent in medicine and approaches to communication in healthcare teaching and learning.

Consensus, specifically consent procedures have been a cause for concern in medicine. Guidelines for practice (General Medical Council 1998) and most recently the Kennedy Report (2001) have put the relationship between effective communication and appropriate consent processes firmly at the centre of public and professional concern. The needs of patients and their families have been clearly

stated as paramount and indeed this thesis would argue so on the grounds of protecting patients basic human needs. Recent National Health Service reforms (DOH 2000) have, for the first time, placed patients and users of healthcare firmly at the centre of healthcare provision. It is still unclear at this stage what impact the reforms will have in reality on health service bureaucracy, health professional behaviours and patients' experience.

However, it is clearly important that medical education responds to the changing demands, attitudes and patients' expectations. Traditional approaches to medical education have not proved to be very helpful in this regard. Reductionism and the biomedical model has resulted in communication problems between doctors and patients (Little 1995) and traditional medical education programmes have held factual biomedical science based knowledge in high regard compared with what may be regarded as 'soft subjects' i.e., communication skills (Wakeford 1983, Hargie 1998).

Communication skills teaching and learning has become part of undergraduate medical (and other health professionals) education to varying degrees (Hargie et al 1998). There are examples of well-developed communication curricula (Kurtz, Silverman and Draper 1998). What remains undeveloped however are firm theoretic foundations on which to justify or explain why and how effective communication is so vital in healthcare. There is an increasing evidence base that confirms positive patients' outcomes such as satisfaction and adherence to treatment (Tuckett et al 1985, Ley 1988) as a result of effective communication, and this is in no doubt important. But this thesis argues that the importance lies in the basic need

satisfaction of autonomy, health and communication in order for patients to be able to participate in society.

Aims of the thesis

This thesis aims to describe the main problems of communication in healthcare together with explanation of why these may be so. Sociological, philosophical and political theories will be drawn on to support explanations given. The importance and changing notions of the doctor/patient relationship will be discussed. Individual autonomy and health will be defined as basic human needs through the use of a general theory of human need. Communication will also be introduced as a basic human need.

A theory of rational and democratic communication will be offered as the appropriate type of communication to meet basic needs as outlined. In addition aspects of clinical communication practice can be analysed using this approach.

Communication teaching and learning in healthcare, specifically in medical education will be reviewed and a strategic approach to teaching and learning communication skills in healthcare will be described as a useful addition to existing models. Basic human needs of individual autonomy, health and communication will remain at the centre of this approach.

Finally a conclusion in the form of a critical review of the thesis will be offered.

THESIS OUTLINE

CHAPTER ONE introduces some of the evidence to confirm that clinical communication is a problem in healthcare, most specifically in medical care. A typology of common problems and perceived barriers to effective communication in healthcare will be set out. These problems will be shown to impact directly and indirectly on patient and organisational outcomes. The notion and nature of the doctor/patient relationship is discussed and how this relates to communication processes and outcomes is outlined.

CHAPTER TWO argues that it makes conceptual and moral sense to consider health in the wider context of human need. Individual autonomy as a basic need is argued to be important in as much as there proves to be an inextricable link with health and autonomy. A universal theory of human need (Doyal and Gough 1991) that sets health firmly within its framework is described and discussed. The notion of good communication as an important component of need satisfaction is shown to be intrinsic in Doyal and Gough's theory of human need. It will be argued that communication can be defined as a basic need on the same grounds as individual autonomy and health within the theoretic framework of Doyal and Gough. The concept of a reflexive relationship between communication, autonomy and health will be introduced. The latter two points are proffered as a development of Doyal and Gough's theory.

CHAPTER THREE will argue that a theoretic approach to communication in collective (societal) and individual terms is needed to understand some of the problems outlined in chapter one and support the concepts of need satisfaction

introduced in chapter two. Habermas' theory of communicative action (1981) and Habermas' other works will provide this theoretic foundation. Themes of consensus, democracy, moral obligations and rationality run through Habermas' work and will be central to the theoretic development of problems and solutions described in the thesis. National Health Service reforms to increase patient and public involvement in healthcare conclude this chapter and will set the scene for further discussion in the following chapter.

CHAPTER FOUR develops the ideas introduced in chapter three and applies them to healthcare. The main focus of the chapter is consensus and how this is operationalised (or not) through consent procedures in healthcare. The Kennedy Report (2001) focused heavily on communication in healthcare and consent procedures and will be discussed as an example for Habermasian analysis. The importance of and related problems with patient and public involvement in healthcare are discussed. The role that health professional education may have in tackling some of the problems in healthcare is introduced.

CHAPTER FIVE describes to what extent medical education has responded to the problems that will have been outlined in preceding chapters. A historic perspective of common approaches to teaching and learning communication in healthcare are outlined to explain the development of the current orthodoxy. Recent models of teaching and learning communication skills, specifically in medicine are discussed. It will be argued that the current orthodoxy in teaching clinical communication in medical education is both successful and problematic. To what extent current teaching makes theoretic underpinnings of communication explicit in the teaching

and to what extent patient autonomy is considered a central issue is discussed. It will be argued that educational development in this field, although moving towards the goals of democratic consensus still fail in some regard to meet the demands of democratic consensus as described by Habermas.

CHAPTER SIX will offer a strategic approach to teaching and learning communication in healthcare that combines the theoretic arguments to support communication, health and autonomy as basic human needs and the communication skills required to meet need satisfaction in these regards. The extent to which this approach minimises the problems outlined in chapter five and maximises the advantages already afforded by recognised and accepted educational methods will be described. The strengths of this combined approach to teaching communication in healthcare (CATCH) will be shown to be: the integration of communication teaching and learning into the institutions of healthcare and health professional education, the combination of theory and skills in individual clinical practice and the continuing development of clinical communication as a recognised subject for academic study and research.

CHAPTER SEVEN will draw some conclusions from the development of the thesis. Each chapter will be taken into account. The main problems and theoretic approaches will be discussed. The degree to which the thesis offers solutions to the described problems will be debated. Suggestions about what else needs to be done to develop theory and learning about communication in healthcare will be offered. Finally how comprehensively has the thesis answered the question in the title, 'Why don't we ask people what they need?' will be decided.

CHAPTER ONE

THE COMMUNICATION OF HEALTH NEEDS IN HEALTHCARE

There is a long history of communication problems in healthcare. This chapter aims to describe the common and recurring communication problems associated with the provision of healthcare that have compounded the difficulties that people have when facing illness. Research spanning more than thirty years into communication in healthcare will provide a background to the developing argument. Patient outcomes will be referred to throughout the chapter. In this way it is proposed that a historic perspective will aid understanding of today's ongoing problems. It will be shown that negative patient outcomes identified in the nineteen sixties onwards continue to be identified today.

Changes in the doctor/patient relationship, along with collective attempts to challenge the power base and balance between doctors and patients will also be outlined. How these changes help or hinder effective communication between doctors and users of healthcare services will be touched on in this chapter and addressed throughout the thesis.

We are in the dawn of the twenty first century, the age of information and technology and yet communication in healthcare continues to fail to meet needs of users individually, institutionally and systemically. Re-organisation of the National

Health Service is an ongoing state of affairs, but core problems rooted in healthcare practice remain. The following quote from the Audit Commission (1993) summarised the situation in the mid nineteen nineties.

> "Patients and relatives often do not get enough information, the communication process is poorly handled, and is conducted in unsympathetic environments. Instead of their needs driving the process, it is shaped by underlying problems in the management and organisation of clinical services."
>
> (Audit Commission 1993 p. 29)

An inquiry into practice in a paediatric surgical specialty in Bristol in 2001 highlighted continuing problems that were reflected of practice elsewhere in the National Health Service.

> "....There is a strong sense that on many occasions communication between parents and some staff was poor. There does not appear to have been any deep thinking about how to communicate information to parents in advance of surgery, nor any systemised approach to it.
> .....to know is to have to face what has been revealed. What we conclude is to repeat that there is a clear need for much greater attention to be given to communication. We take the view that there were occasions when the communication between clinicians and the parents in Bristol was less than adequate. But, against the standards of the time, the practice was probably not greatly different from that which clinicians elsewhere thought appropriate."
>
> (Bristol Inquiry chap 17, point 9, 2001)

Health professionals are in the business of meeting health needs. These may be in the form of preventative, curative, palliative or rehabilitative provision. But we need to understand and agree what health needs are before we can be sure we are meeting them. The term 'health needs' is frequently used but it does not follow that definitive terms are agreed. The problem of different definitions and perspectives of health itself compound this.

There are recurring problems with regards to communication in healthcare (Ley 1988). Despite ample evidence of positive clinical outcomes in the light of effective or good communication, health professionals have, in many instances, failed to address the known communication problems in healthcare, as the quotes above illustrate. Around half of patient complaints and concerns are not recognised by doctors (Stewart et al. 1979). In addition to physiological or organic disease patients commonly present with psychosocial and psychiatric problems, but up to 50% of these diagnoses are missed (Shulberg et al.1988, Freeling et al.1985).

There are also substantial difficulties of consensus between patient and doctor. There is disagreement about the main health problems in around 50% of individual doctor patient consultations. Such mismatches are often a result of difference in patient/doctor perspectives (Starfield et al. 1979, 1981). These differences can be due to any number of reasons; one of which is language. In this instance we are not talking about language exclusively in the sense of nationality, but rather the difficulties which occur as a result of differences between health professionals' language and that of lay people. Some of these have not been resolved so far in medical education and practice. The specialised language health professionals' use is an important means of communication for them but tends to exclude the patient and prevents understanding. Therefore, it is hardly surprising that patients feel dissatisfied and complain about the lack of opportunity for shared meaning in their healthcare encounters (Frances et al.1969, Faden et al. 1981).

There is nothing new in the statement that *'communication in healthcare is fraught with difficulties that have not been resolved over the years'* (Ley 1988). The question is why is it considered to be such a significant problem now? In the past patients generally accepted a paternalistic "doctor knows best" approach. Doctors expected their patients to "do as they were told".

> "Physicians often saw little point in informing patients, preferring to make recommendations that their patients were supposed to accept and with which they were expected to comply."
>
> (Wear p.23 1993)

That is not to say that all doctors expected this but, generally speaking, National Health Service (NHS) patients at least, did not overly question their doctor's decisions or advice. In the past it is fair to say that for most health problems there was reduced choice in treatments. Think of the range of treatments available, for example in pain control, even as recently as the post war period, as compared to the plethora of complex medicines and anaesthetic procedures available now.

Public education through education systems, professional and voluntary bodies and media coverage on health matters has reflected a sea of change and developments in recent years. Some of these changes have been in healthcare itself and other wider systemic and cultural change, which have impacted on the healthcare system. Examples of such change are:

- increasingly multi-cultural societies (Helman 1991, Skelton, Kai and Loudon, 2001)
- changes in the doctor/patient relationship
- expectations of patients

- lay access to medical and health related information (NHS Direct)
- increased complexity in technology and range of choices in medical treatment

Effective communication is not always easy, but necessary. It also needs to be said that better communication will not solve all our problems in healthcare. Common problems such as patients complaints, non-adherence (or concordance in more recent terminology which reflects the conceptual change in the doctor-patient relationship aiming for a more consensual shared model of understanding) to treatment, sub-optimum patient health outcomes and patient dissatisfaction are examples however, that may be responsive to effective communication practices (Eisanthal et al. 1990, Di Matteo et al. 1986, Roter et al. 1995).

The uniqueness that individuals bring to any human communication results in complex and dynamic interactions. Given awareness, understanding and the motivation to improve our communication we ought to aim to do our best, but some problems are like mountains, they are simply there. What communication can do is help with recognition and understanding, even in intransigent problems. Most importantly, it will be argued in this thesis, if patients needs are not met at the level of communication then health professionals are failing in their task of considering the patient as a whole, which is a common patient complaint and something that a significant percentage of patients want (Little et al. 2001).

It is assumed that the intention of healthcare professionals is not to have patients going away feeling dissatisfied (Ley 1988), refusing to adhere to advised treatments (Thompson 1984), failing to understand or remember what the doctor has told them (Which 1991). But with regular monotony these are the outcomes and continue to be

so. The outcomes, therefore, do not match the original intention. That is to say, health professionals do not consciously aim to increase patient non-adherence to treatment through their communication, rather the opposite. Nevertheless, non-adherence remains a significant problem in medicine (Butler et al. 1996). The common problems that recur as a result of poor communication in healthcare will be discussed in this chapter. Subsequent negative outcomes will be discussed and the direct relationship with antecedent communication structures and processes described.

1.1 IS THERE AGREEMENT OVER THE NEED FOR EFFECTIVE COMMUNICATION IN HEALTHCARE?

Communication has not been considered explicitly or specifically in healthcare when discussing health needs. In general terms good communication is vaguely agreed upon as a good thing and even necessary, but what this means and what it entails is not always specified. Statements such as, 'communication must be improved', or 'there was a breakdown in communication', are common statements in audits and service evaluations. These reflect problems at all levels. They may be structural issues involving mechanisms for organisational transfer of information as highlighted in the Audit Commission (HMSO 1993). Or indeed they may be what actually happens at the clinical interface, between provider and user. There is no agreed theoretical framework of what we mean by effective communication.

"Many patients are manifestly unhappy with much of the communication that takes place between them and their doctors. Lack of information about the diagnosis, prognosis and therapeutic options can cause anxiety, uncertainty, distress and dissatisfaction. These problems can also produce misunderstandings about the importance of different diagnostic tests, under reporting of side effects and symptoms, and they may negatively influence

> motivation to accept treatment.....Such an unsatisfactory situation is disturbing for patients and their families, but is also professionally and personally unrewarding for the doctor."
>
> (Audit Commission 1993 p. 21)

The need for effective communication processes is implicit and reiterated in the literature and anecdotally over the years. The development of the Patients' Charter (1991), now abandoned, brought attention to communication issues and the need for health professionals to be effective communicators. A list of rights in the Patients' Charter included the following points that related specifically to communication:

> "To have proposed treatment explained to you, including any risks involved and any alternatives.
> To have access to your health records and to have your records kept confidential.
> To have any complaint investigated and get a quick, full, written reply."
>
> (Patients' Charter 1991)

The above points have been reconfirmed and developed in the General Medical Council's recommendations *'Good Medical Practice'*, 1998. Sir Donald Irvine, President of the General Medical Council (GMC), made the following statement:

> "The medical profession needs to develop habits, strategies and tactics for engaging the public directly. It must become able to explain how medicine works, it's limitations as well as it's potential..... In the shifting relationship between the public (as recipients of healthcare), the employers and health professionals, ways should be sought to make sure that patients, their relatives and carers have sufficient information, sufficient choice and sufficient autonomy to feel that they are effectively in charge. Openness, inclusiveness and transparency are key qualities of effective regulation."
>
> (Irvine 2001)

However, the implementation of effective communication is problematic. Methods in research and education employed to attain effective communication in healthcare so far have not become fully integrated into everyday practice enough to make significant impact upon patients' outcomes. (This point will be addressed more fully

in section 1.2). This is despite widespread agreement that effective communication is a good thing - a stance taken by many health practitioners. It is not simply a case of professionals not agreeing with the basic argument, (which would make the current dilemmas easier to analyse), as most do. Simpson stresses in the Toronto Consensus Statement that,

> "Effective communication between doctor and patient is a central clinical function that cannot be delegated. Most of the essential diagnostic information arises from the interview, and the physicians interpersonal skills largely determine the patients satisfaction and compliance and positively influence health outcomes."
>
> (Simpson et al. 1991)

Communication between humans is a complex process and there are many factors that affect communication in healthcare. What makes for 'good' communication in healthcare is still a matter for debate. However, the growing evidence that the quality of clinical communication is related to positive health outcomes is persuasive. Research has identified some aspects of the communication process which are particularly important in this regard. Despite such evidence, communication has not been considered, or valued highly enough in many instances, as the dynamic necessary to help meet health needs (Kaplan et al. 1989, Orth et al., 1987, Stewart et al. 1979, Starfield et al. 1981, Bass et al. 1986). To consider the position further, problems can be divided into two categories: problem indicators in terms of patient outcomes, and barriers to effective communication.

1.1.1 Problem indicators

The problems of communication in healthcare thus can be can be identified in terms of patient outcomes and divided into five main themes: complaints; patient

satisfaction; concordance; understanding and recall; and health outcomes. These themes will be examined more closely next, bearing in mind it is not an exhaustive list. Barriers to effective communication include professional skills, sociocultural issues and language.

1.1.2 Complaints

The Health Ombudsman's reports over recent years (2001-2002) indicate that communication and attitude are the major reason for patients and relatives complaints, hard evidence that communication is a problem in healthcare. There are many examples of poor communication cited in the literature. Most complaints by patients and relatives about doctors and other health professionals are about communication problems, not clinical acumen (Richards 1990).

People are amazingly forgiving and tolerant in healthcare. Complaints, if dealt with informally and timely with patient participation, can in some instances, be resolved by explanation and apology (Pietroni and Uray-Ura 1994). Even medical or nursing mistakes, if dealt with sensitively and with a sense of genuine contrition and honesty, can usually be sorted out in the clinical situation, and do not get as far as complaints committees and ombudsmen. This is not to say patients or relatives should not complain to these bodies or even that they should be discouraged. It is just that most people do not want to go through these processes at a time of stress, anxiety or bereavement. Complaints procedures themselves are recognised as being complicated, elaborate and lengthy. Recent changes in the NHS complaints procedure (Department of Health 1996) have made some moves to make them more

user friendly. Panels now include lay representatives, but fully independent investigation is not made. The decision to set up a review panel is taken by a board member of the health organisation in question when it is agreed that attempts at local conciliation have failed.

As well as needing information and explanations, people also need to sense that despite the fact that something went wrong the doctors and nurses really care about what has happened. They express a desire for health professionals to demonstrate that they care about them, and are indeed themselves distressed when things do not work out as well as they might (Richards 1990). They commonly wish for their experiences not to be repeated with others. The following extract illustrates typical complaints about health professionals:

> *"...When I asked my solicitor to ask for a written apology they said 'No way'. They have admitted negligence, they have offered compensation, they meant to make amends - but they won't give me an apology - 'Yes, we did do it but we're not sorry!' sums up their attitude".*
>
> (Vincent et al. 1994)

The last two examples may suggest that health professionals are somehow immune or cavalier to mistakes or errors of judgment. This is not the case. Health professionals, in the main, care deeply about their patients and the standard of their practice. When errors are made they may or may not have the support and help they need to cope, and communicate this to those on the receiving end (Garrud et al., 1990, Christienson et al. 1992)

> "There is a big tendency when you have a dying patient or a bad result not to want to go in the room. You feel so bad and so guilty that it's hard to go in the room. It's good to work things through by just being, doing what you do

> every day. Keep doing it and you get through it. But I wanted to avoid it. My natural instinct was not to go in the room, and pretend it wasn't there and not have to look the people in the eye."
>
> (Christienson et al. 1992)

In cases of gross medical negligence or serious errors, health professionals have a duty to be accountable for their actions, and patients have a right to expect a timely assessment of their case. In the case of complaints, communication holds a special importance (Vincent et al. 1994). People are disturbed by a perceived lack of honesty, absence of explanations and the reluctance to apologise, all of which require sensitivity and communication skills.

Even when people do not actually complain about their experiences, research and practice shows that poor or ineffective communication still disadvantages people (Meridith 1993). Adherence to advice and treatment, understanding, recall and recovery times as well as specific clinical outcomes are all affected by communication. As an overall view, the level of complaints is a reflection on the level of patient dissatisfaction, but may be the tip of the iceberg.

1.1.3 Satisfaction

Patients' satisfaction is a critical indicator of the quality of communication in healthcare. In the now classic work Korsch and Negrete made the point that,

> "Systematic surveys confirm that there is widespread dissatisfaction among patients with doctors and among doctors with lack of cooperation by their patients. Of the various factors that tend to contribute to this discontent, certainly one of the most important is poor communication between doctor and patient. In modern medical practice, which is now focused predominantly on technical knowledge, the physician may be engrossed in technical concerns and arcane terminology that mystify the patient."
>
> Korsch and Negrete (1972)

Meta-analysis of research looking into patient satisfaction with communication in a variety of health settings, over twenty years or so, is stunning in its depressing conclusion. Two large studies by Ley (1988) and Roter (1989) showed that despite regular research, there appeared to be no evidence that patients' dissatisfaction or levels of non-concordance were diminishing. The research included areas in hospital care and the community. Furthermore, results do not significantly vary in relation to the year of publication. Later studies, in the mid-eighties, fare no better than studies carried out in the sixties. This is an interesting observation as evidence was emerging through research, linking the relationship between effective communication and positive patient outcomes. The only reliable conclusion that can be reached is that despite the evidence of a need for effective communication in healthcare, and recognising attempts to achieve this in some cases, improvement in patient satisfaction cannot be found in significant levels in practice.

Rising patient expectations may explain in some part why the levels of complaints were not diminishing. However, Davis and Fallowfield (1991) also make the point that the levels of dissatisfaction in these studies although unacceptably high - up to 65% - are likely to underestimate the actual or real level of dissatisfaction. The reasons for underestimation may include, for instance, the deferential attitude many patients have towards doctors. Doctors enjoy a degree of high status and have the knowledge, resources and skills that patients perceive they need. Patients who are used to an authoritarian doctor may feel uncomfortable about questioning or criticising for fear of displeasing the doctor and the unfounded fear that future treatment may be jeopardised as a result. The popular belief that a doctor can be a good doctor even if bereft of social skills has not altogether gone. Statements such

as; 'He's not very good with patients, but he is a really good doctor' need to be challenged. There is more to being a good doctor than technological proficiency. But if the patient's expectation is that doctors do not communicate well, but generally deal with the physical problem and they are grateful for that alone, they may not consider the interactional aspect as important when responding to satisfaction surveys.

The timing of any questionnaire, whether or not it is self-completing or confidential is also likely to effect the response. Similarly, methodological issues such as the question of who carries out the survey raises another difficulty. A member of the healthcare team dealing with patient satisfaction issues or an independent researcher provides additional variables, which might influence outcome.

> "These results may also underestimate the real situation because of the tendency to give socially desirable responses to questionnaires, the anxiety involved in directly criticising the doctor (since their treatment may be adversely affected) and because patients expectation of professional behaviour might be low."
>
> (Davis and Fallowfield 1991 p.5)

Although there are some recognised difficulties with measurement and methodologies in patient satisfaction studies, there can be little doubt that patients remain dissatisfied with their experience in healthcare in some instances. Fitzpatrick (1984 pp. 154 - 175) raises the point that there are weaknesses in the concept of patient satisfaction and the difficulty of comparing studies. He suggests that the use of a systematic approach influenced by psychological function (health outcomes) would be more suited to use in the design and measurement of patient satisfaction.

This has not been the case and failure to do so has tended to result in ad hoc conceptions of patient satisfaction.

Professional perspectives have dominated much of the research, rather than what is important to the patient with regard to their health problems and healthcare. The main thrust of the research is doctor-centred, that is from the perspective of the physician, with 'patient-centred communication' studies providing less than half the research data. This means that much of the research considers patient satisfaction in areas which clinicians and professional health researchers believe to be important. There is little emphasis in the research on what patients believe to be satisfactory (Fitzpatrick 1984 p.174). Some studies in the nineties did show that patient-centred interviews were more likely to result in increased patient satisfaction (Arborelius and Bremberg 1992, Little et al. 1997)

However whether things 'really' are not getting any better, or indeed whether health professionals have improved in their attempt to meet patient satisfaction through better communication is in fact not entirely clear. Studies in the nineties continued to show that patients' expectations and concerns were not met within medical encounters. (Joos et al. 1993, Little 1997). The NHS has been through significant changes, and certainly patient expectations have not remained static over the last thirty years. However the significance of the impact and effect of these two factors is not known. At this present time one can reasonably hypothesise that health professionals' ability to meet patients' needs on the level of communication has not developed in line with patients' expectations and demands for effective communication.

A more specific hypothesis for the high level of dissatisfaction is that patients do not give doctors feedback in the form of questions, and therefore, the doctor might be blissfully unaware of the ineffectiveness of his or her own communication (Ley 1972, Roter 1977, 1983). Thus, a health professional may give lots of information, cover all the points on her/his agenda, diagnosis, treatment, likely side effects and outcomes and feel thoroughly satisfied with her/his performance. There may be several reasons for a patient's dissatisfaction despite all the points covered by the doctor. The doctor's communication may not have been received and processed in the way the doctor believes it has; the patient simply has not understood everything; the patient is expecting or needing different information; or the information doesn't match what the patient believes is important with regard to their health problem (Calnan 1988, Tuckett et al. 1985).

A study by Beckman et al. (1984) provides insight into another reason why the doctor-centred approach gives rise to problems. The doctor very often interrupts patients soon after they have begun to tell their story (on average 18 seconds). After interruption the course of the consultation follows the doctor's agenda, patients then fail to disclose other significant problems and concerns.

The fact that people do not ask questions does not mean that they are satisfied with the content or nature of the communication. Korsch et al. (1968) found that 24% of parents of paediatric patients did not ask the doctor questions even though they wanted more information. An enormously significant 76% of the patients' main worries and 63% of their expectations of treatment were not communicated to the doctor. Similar findings have been found in other studies such as Carstairs (1970),

Fisher (1971) and Ley et al. (1975). Klein (1979) carried out a large scale British survey and reported that almost half of those who wanted to make requests for further information failed to do so. More than twenty years on The Bristol Inquiry also highlighted a recognised need to tailor information to the 'needs, circumstances and wishes of the individual' (Bristol Inquiry chap 30, rec:6, 2001)

A recent communication audit carried out in an out-patient department of a London teaching hospital supports earlier studies (Gill, O'Neill, et al. 2003), in as much as discourse analysis of audio taped out-patient consultations showed that doctors did not encourage patients to ask questions, but they reported that they had. More interestingly however was that patients also said the doctor had given them the opportunity, or encouraged them to ask questions, even when detailed discourse analysis demonstrated otherwise.

The lack of questions on the patient's part, as described by the research cited so far, seems to be a combination of several issues. Patients are disadvantaged by the mismatch in language, and or jargon, and not seeing the relevance of the course the doctor has decided to follow as it does not represent what patients consider to be their main problems. Hence, merely asking,"Do you have any more questions?", will not necessarily result in the patient asking for information. They may not want more information about what the doctor has been talking about. Some patients will hold a deferential attitude towards doctors and the expectation to listen to the doctor and take advice unquestioned still happens in practice. The opportunity or atmosphere in which patients feel they can talk and ask questions relevant to them is important, and plays a part in patient concordance. This issue will be considered next. This has as

much to do with the nature of the *relationship* between the health professional and the patient as it has with the structure and content of the medical interview.

1.1.4 Doctor-Patient concordance

'Concordance' is the term developed from the previously termed *adherence*, or *compliance*. The conceptual shift in concordance means that a patient agrees with and follows advice on a course of treatment as a result of shared discussion with the doctor or health professional. This is a change from the patient passivity implied with compliance, and to some extent adherence. Although it could reasonably be argued that adherence is not a passive term as this does not imply that the patient has not been involved in discussions to reach agreement. It means that the patient has, for whatever reason, not been able to stick to what was agreed. Reasons for non-concordant behaviours in-patients can be multifactorial (Britten 2003, Horne 1998). Some of these are: the duration and complexity of treatment; the patient's own understanding and belief in the efficacy or credibility of the treatment; costs in terms of behaviour change and how the treatment fits in to their lifestyle; the support and encouragement needed to see the patient through painful or difficult stages; and any problems or iatrogenic results of the treatment itself.

Having the opportunity to talk to the health professional about their health problems is as important in regard to patient concordance as it is in patient satisfaction. But this in itself is not sufficient and is not always well managed in practice. Even when patients do have the opportunity to talk, it is often in the nature of giving information in response to the doctor's questions. This is opposed to interaction

instigated by themselves, or drawn out by the doctor or other health professional to help the patient meet their own agenda (Roter 1988). This is called a doctor-centred approach. Physicians also tend to over estimate the time that patients talk during a consultation. In fact doctors almost always talk more than patients do (Beckman et al. 1985). If the patient does not have the opportunity to put forward her problems, and what it means to her, then how does she know or believe that the doctor is responding appropriately with a diagnosis or treatment plan? The following example taken from Korsch and Negrete, although taken from a study over twenty years ago, remain pertinent today, is illustrative of a number of problems in such an encounter.

> "A Mother in a state of high anxiety about the severe coughing of her infant son takes him to a hospital clinic. The physician, without greeting her or addressing her by name, asks a few matter of fact questions and examines the baby. He finds that the child has a post nasal drip of mucus {from an inflamed sinus} that is causing the cough. Without explaining the cause to the mother, the doctor simply prescribes nose drops, steam inhalation and perhaps an antibiotic and asks the mother to return with the baby in a couple of days for a follow up examination. The mother, disappointed that the doctor has apparently shown no concern about her distress over the baby's cough, and unable to see how the prescriptions could stop or relieve the cough, buys cough medicine at the local drugstore instead of using the prescribed treatment. She does not go back to the doctor for a follow up. If the cough actually betokened a serious underlying condition, she has left the baby in jeopardy. The physician, for his part, writes her off as an uncooperative parent because she has not returned."
>
> (Korsch and Negrete 1972)

A patient dissatisfied with a doctor's dismissive attitude may turn to her own resources and instincts and go by them, or to another source where she feels listened to. This may be perfectly fine of course, but the danger as highlighted in the above example is the occasion when poor communication results in negative concordance behaviours in the case of serious disease. In cases such as these, health professionals

could be said to be causing actual or potential harm to their patients, which goes against their best intentions and aims.

The above example does not suggest that the mother had difficulty understanding what the doctor was talking about as such, but she was dissatisfied with the doctor's manner and attitude towards her and her child. However, poor understanding and recall is a known to be affected negatively by ineffective communication. Such an outcome is potentially damaging to patients. This is discussed in the following section.

1.1.5 Understanding and recall

Even when patients are included in communicative activity there remains an alarmingly high percentage of patients who fail to remember what they have been told about their diagnosis or treatment (Toronto Consensus 1991). It is not just the case that clinicians are not trying to communicate with their patients, but for a myriad of reasons patients still come away from consultations either confused or simply not understanding what is going on. An independent consumer survey came up with similar results,

> "One in five....left the clinic without any clear understanding at all."
> (*Which?* 1991)

Ley (1988) puts forward the notion that there are two main reasons why patients fail to remember what they were told. Firstly, they are likely to misunderstand clinical information because it is presented to them in a too difficult form and secondly,

patients may be reluctant to ask questions in the clinical encounter. With regard to the first point; it is not just the use of medical terminology that proves problematic, but statements of advice, for example on medication packs. Terms such as, '*Do not exceed the stated dose*', and '*unless otherwise directed by the doctor*', also pose difficulties for some groups, (Adult Literacy Support Services Fund 1980).

Research shows that it is not only the less well educated that have difficulty in understanding directives (Cole 1979). But better-educated groups have similar problems too. Terms that are used in other contexts than medicine might be reasonably thought of as non-problematic, but this is not the case. The word '*chronic*' is an example of different medical and lay meanings. In medical terms chronic relates to disease or symptoms present over a long period of time. Treatment of chronic illness revolves around management, not cure. Many chronic illnesses are not curable, rheumatoid arthritis is one such disease. The contemporary use of the word 'chronic' in lay terms, or as used by the young, can mean, 'dreadful, out of fashion, or embarrassing'. Cole (1979) included polytechnic students in a multi-choice questionnaire for health education purposes and found words such as, 'dilated', 'emaciation' and 'endemic', misunderstood. These examples are terms which clinicians assumed to be well understood in a climate of increasing media attention to medical and health matters.

> "It therefore seems safe to conclude that there is at least some risk of people being presented with words whose meaning they do not know in a variety of health related settings."
>
> (Ley 1988 p. 19)

The second point; patients are reluctant to ask questions in the clinical encounter may also be multifactorial. One reason for this might be an over deferential attitude towards doctors (Ley 1988). (This aspect is explored in more depth later in the chapter when considering the impact of health professional-patient relationships). The *'Which?'* survey (1991) came up with 11 reasons why patients do not ask questions including 63% of people assuming the doctor had told them every thing they needed to know. 31% said it did not occur to them to ask questions which is a surprisingly high figure. It would seem therefore, that the idea of the onus being on the health professional to help patients to think and ask questions pertinent to them is even more crucial.

This raises a tentative query with regard to the notions of risk and harm. Misunderstanding and reluctance to ask questions can pose a real problem for health professionals and patients. As either can make erroneous assumptions about unchecked information. At face value it may seem that to link lack of understanding with harm in this way requires a spurious cause and effect argument. But as the resulting outcome of misunderstanding or lack of understanding can be negative health behaviours then it can be defined as harmful. The relationships between health, illness and harm are explored in the next chapter.

1.1.6 What is the relationship between understanding, doctor-patient concordance and satisfaction?

The relationship between understanding and doctor-patient concordance is more complex than a simple cause and effect relationship. Patients may have good understanding initially but forget over a period of time. Patients may have good

understanding, do not forget, but reject what the health professional has said. Patients do not understand and do not adhere to advice or treatment.

There is a strong relationship between patient non-concordance and dissatisfaction with communication in the medical setting (Korsch et al. 1968, Becker and Rosenstock 1984). It seems reasonable in linear logical terms that understanding, concordance and satisfaction are inter-dependent to a large degree. We need to understand anything before we can make any form of rational judgment. That is, there is a need to understand what any proposed healthcare means before the experience can be agreed upon, or judged. The level of understanding will vary with individuals. Moreover, the need to adhere to advice or treatment, at least on some level, would seem a reasonable supposition, before any subjective responses in terms of satisfaction with said healthcare can be justified. Understanding may be at the level of feeling: *'It was painful', 'I felt frightened', and 'I felt cared for'*. Or it may include higher cognitive understanding and intellectualisation. It is still not clear how much patient adherence to treatment and concordance between doctor-patient and satisfaction is dependent on the amount of mutual understanding reached between the patient and professional. Doctors may be unaware when patients disagree with proposed courses of action because they fail to check (Tuckett et al. 1985).

Hypothetically, it may be the case that high levels of understanding are more likely to lead to increased concordance and satisfaction. Conversely, low levels of understanding are more likely to lead to diminishing returns in concordance and patient satisfaction.

However, a simple linear approach alone is not enough to deal with the problem. We can understand something, but not relate it to ourselves personally if it conflicts with our own belief system (Helman 1991). If this is the case, then intellectual understanding itself will not make us more likely to take up advice and treatment or be satisfied - just the opposite, we may not be able to remain at all and will seek alternatives. It is also possible to understand information and be in a position of non-agreement, or unacceptability. There could be many reasons for this. Conflict with belief systems is certainly a tremendously important one. The advice may be unrealistic, or difficult to follow if it does not fit in with the beliefs, which influence decision making and lifestyle. If the patient finds difficulty in seeing the relevance of the advice and treatment then he may well come away feeling dissatisfied and likely not to take up the advice or treatment (Britten 2003).

For example, attempts to get older adults to give up smoking may fail. There is significant evidence to demonstrate that lung tissue shows degrees of recovery and cardio-vascular performance improves when an individual gives up smoking, even after many years (Health Education Authority 1998, Pelkonen et al. 2000). Yet a common response from such individuals is "*It's too late now, I've been smoking for all these years. I can't see that giving up now is going to do me much good*". Of course there may be many factors that have led to the person coming to this conclusion other than understanding. The patient may understand and accept on rational terms what is being said, but still finds it extremely difficult to adhere to advice at this point because of the complex and powerful addiction to cigarettes. Individuals will find ways of justifying their negative and risky health behaviour, despite the evidence (Evangelista et al. 2003).

If however the concept of understanding is widened to include the health professionals understanding of the patient's beliefs, concerns or expectations then maybe the relationship would be a stronger one. By developing a more dynamic relationship between the health professional and patient, the opportunity and environment for two-way communication and mutual understanding may be reached. Conclusions would not be reached on whether the patient has understood or agreed in terms of the health professional's perspective alone. To reach understanding about anything we need communication skills and healthcare professionals need additional professional skills.

By accepting the argument, in light of the evidence, that communication has a major role in patient understanding and uptake of treatment, then it could also follow there is a relationship between the patient health outcomes and the antecedent communication. Research shows this to be the case, as will be discussed next.

1.2 HEALTH OUTCOMES

Research has shown that effective communication impacts directly on health outcomes. For the purpose of this text outcomes will be divided into physical, post-operative, palliative care, emotional and mental health. Effective communication can be seen as a therapeutic intervention in its own right (Stewart et al. 1997)

1.2.1 Physical

Communication impacts upon physical outcomes. Mazzuca (1982) reviewed twenty seven studies concerned with chronic disease and found that there were significant effects upon patients experiences in a variety of diseases. This meta-analysis indicated positive effects in terms of specific therapeutic goals and long term outcomes such as return to work or re-hospitalisation. Groups that had received explicit and recognised communicative intervention sustained better long-term outcomes than about 78% of controls, who had not received explicit and structured communication.

Over twenty years ago evidence began to support the notion that there was a positive relationship between good health professional/patient communications and better outcomes for patients. Gruen (1975) found that patients who had had a myocardial infarction, and were randomly allocated to daily health professional counselling (a model of communication in which patients are encouraged to talk about their beliefs, fears and expectations as well as offering advice to patients) fared better than the control groups of patients. Counselled patients stayed on monitors for less time, remained in intensive care and hospital for less time, had less congestive cardiac failure and fewer arrythmias than the controls. A similarly encouraging picture is offered in longer-term rehabilitation following a cardiac episode. Pozen et al. (1977) included a nurse rehabilitator offering information, helping to minimise anxiety and discussing plans for return to normal life. Results showed that at a six month follow up session the intervention group was more likely to have returned to work, and have gained and maintained higher function status in general.

McKenny et al. (1973) demonstrated in their study that patients with hypertension did significantly better if exposed to additional information about their medication by pharmacists with regard to blood pressure control than a control group, who were subject to the usual level of care. With increased knowledge the patient's level of adherence to advised treatment was increased and this improved their health outcome. A later study by Orth et al. (1987) showed that hypertensive patients' blood pressure readings were significantly reduced when patients were allowed to express their concerns without interruption as opposed to a predominantly closed questions approach.

1.2.2 Post operatively

Several studies have demonstrated the benefits of effective communication in post-operative recovery. These range from using 'superficial psychotherapy' techniques, Egbert et al. (1964) to the study of the provision of different types of information prior to procedures. All studies have been unanimous in concluding that effective communication is a consistent factor in reducing post-operative symptoms and encouraging recovery. Mathews and Ridgeway (1984) concluded in their study that information, instruction and training in cognitive coping techniques were beneficial, particularly if sensory information was used. Sensory information means using language rich in sensory words such as; feel, hear, touch, think, smell, or taste. Sensory language associates us into an experience; that is, we relate it to our selves rather than to another person or in a detached way (Bandler and Grinder 1975). Sensory based information also helps recall. Mathews and Ridgeway (1984) found that patients who were highly anxious benefited from such techniques. These

findings have been further substantiated by other studies. Johnston (1990) reviewed 35 randomised controlled trials and concluded that psychological methods based on effective communication '*have been shown to be effective in reducing pain, reducing analgesic use, reducing patient distress and increasing patient satisfaction and care*'.

1.2.3 Palliative care: symptoms

Effective communication and counselling can also influence the outcomes for patients with life threatening disease. Symptoms related to terminal illness and its treatment were reduced in-patients who received counselling in comparison to control groups (Forester et al. 1985). Some studies claim to show an increased survival rate where more sophisticated communication processes and skills such as those employed in psychotherapy and hypnosis have been used (Spiegel et al. 1989, Grossarth-Maticek et al. 1984). It has to be recognised however, that there are methodological difficulties with some of these studies and results are not unanimous. To understand and analyse the processes of change that might be going on with this group of patients a large number of variables need to be taken into account.

1.2.4 General Practice: emotional/mental health

In general practice, chronically neurotic patients who had counselling were significantly more likely to come off psychotropic drugs. In a larger study, Waydenfeld and Waydenfeld (1980) demonstrated that with effective counselling

there followed a large decrease in surgery attendance, a decrease in psychotropic and other drug prescriptions. Around 80% of the sample rated as either very much, or somewhat improved. This included patient's self-rating which was generally in accord with that of the professionals. Although the Waydenfeld study needs to be treated cautiously, as there was no control group or independent evaluation, it nevertheless demonstrates a trend that is borne out by others. Holden et al. (1989) carried out a study looking specifically at depression in the post-partum period. Health visitors underwent a short training course in communication and counselling and counselled a randomly allocated group. This well designed study demonstrated a significant improvement in the intervention group showing 69% improvement in the counselled group against 38% in the control group.

Roter et al. (1995) showed in a randomly controlled trial that if primary care physicians received training in problem solving and dealing with patients emotions, then detection and management of pyschosocial problems was improved and that patients emotional distress could be reduced for as long a six months. Other earlier studies demonstrated the link between effective communication and diagnostic accuracy. More accurate and relevant information is gained about symptoms, course of the presenting complaint, previous episodes, effects on the patient, any current treatment and psychological difficulties the patient may be undergoing (Rutter and Maguire 1976).

Effective communication is part of the basis for counselling. That is not to say that health professionals have to train to be counsellors *per se* but that they will need to develop an understanding and levels of competence in communication skills which

are used in counselling. The expectation that patients improve to a greater extent and faster, are exposed to less potentially harmful miscommunication, and feel better supported psychologically, emotionally and socially are all outcomes which can be met (Davis and Fallowfield 1991). Studies have been conducted in a variety of clinical settings and cover a range of what might be considered good communication. This range includes basic counselling and communication skills ability, achieved through short training courses, to the inclusion of formally trained counsellors.

The benefits described above are significant, consistent and have been compiled over a period of more than thirty years, yet we continue to have problems in persuading healthcare professionals that such benefits can be achieved through effective communication. Some of the barriers to effective communication, and reasons why the problem persists are considered next.

1.3 BARRIERS TO EFFECTIVE COMMUNICATION

1.3.1 Professional skills

One of the major factors in the longevity of communication problems in healthcare is the continuing and widespread deficiencies in professional communication skills. These present themselves with regular monotony on a pragmatic level, that is, what is actually done or not done in clinical practice. Some of these skills are not special to healthcare. They are to do with everyday common courtesy and generic communication skills. Some skills are more specific and relate to medical tasks.

Examples of these might be a physical examination or explaining a procedure. Davis and Fallowfield (1991) provide a long list of deficiencies which is worth expanding on and considering in more depth, especially what impact or effect this lack of skills can have on patients in terms of outcome.

Health professionals may fail to greet patients appropriately and fail to introduce themselves, or explain their own actions. Aside from giving a bad first impression, this can result in responses of not feeling respected and valued, and anxiety over what to expect. Health professionals may also fail to elicit easily available information, especially major worries and expectations. Thus patients are not encouraged to ask questions which they feel are appropriate for them, as mentioned previously.

Such failures lead to further problems. The health professional may accept imprecise information from the patient. Failure to seek clarification or check for mutual understanding can lead to focusing too quickly without hypothesis testing. This may mean missing out on important information needed to reach an accurate diagnosis, acceptable treatment and care plan for the patient. This point is often reached due to a traditional medical interview style, a concentration on closed questioning, frequent interruptions by the doctor and failure to let the patient speak spontaneously (Beckman and Frankel 1984). The patient's feelings and perceptions are commonly avoided (Beckman et al. 1985). This avoidance can be aided and abetted by the conscious or subconscious neglect by the health professional of non-verbal and verbal cues from the patient. These may be critical factors. It is common to avoid exploring information about personal, family and social situations in any depth. The

Bristol Inquiry has again been helpful in bringing the medical professions (and indeed other health professionals) attention to the identified the common communication practice of health professional led and controlled communication.

> "Communication often only stays at the clinical level....The patient needs to be listened to in what ever form they express themselves..."
>
> (Bristol Inquiry chap 2, rec: 33, 2001)

This can lead to patients and relatives dealing with feelings of not being understood, or listened to, unsupported, not perceived as an individual and frightened. This also results in problems in cognitive terms. Distortion of available information or fantasy will come into play. In other words, when individuals do not have complete information there is a natural tendency to hypothesize or speculate with the information at hand. This will vary depending on the beliefs, knowledge and experience of the individual. Either way there is a need to try and make sense and to fill the gap of the much-needed additional information. This process has implications for the health professional and patient. Both may make assumptions about each other and the healthcare episode, and both could be different.

Health professionals also fail to provide adequate or appropriate information about diagnosis, treatment, side-effects or prognosis. Other studies support Davis and Fallowfield in the argument that professional skill is one of a number of barriers that block good communication, (Di Matteo 1994). Patients who have negative test results need more than to be told there is nothing wrong (Fitzpatrick 1996, McDonald et al. 1996). Patients who have serious disease also need to know about

their diagnosis and treatment (Meridith et al. 1996). At both ends of this continuum of health a need for effective communication remains constant.

The reductionist approach in the biomedical model of medicine is also a problem for communication. The person can be reduced to a patient, further reduced to a biological system or disease, and reduced yet again to a symptom or intervention (Doyal and Gough 1991). Widening out medicine to include socio-cultural influences is however problematic for health professionals, and enormously complex. Taking such a path tests individual communication skills, and as we have discovered health professionals are often lacking in basic skills. Some examples of these problems are turned to next.

1.3.2 Socio-cultural problems

The important arena of informal care and treatment that is outside the healthcare system, is what people rely on for the treatment of every day ailments. And even when people do consult their doctors and are given prescriptions it is common for them to take them in a way which makes sense to them rather than as the doctor has advised (Helman 1991). In an attempt to clarify the complexity of socio-cultural problems that this poses it may be useful to reflect on professional/patient perspectives, belief systems, and language.

1.3.3 Professional-patient perspectives

Patients and doctors may meet each other from widely differing perspectives. The doctor will have a disease perspective and the patient is more likely to have an illness perspective. Hellman (1991) has described the basic premise of the medical perspective. Health professionals become encultured into the disease perspective of ill health through the medical education process. This tends to last throughout their professional lives and will replace their previous lay beliefs. The disease perspective claims scientific rationality as its foundation. There is an emphasis on objective numerical data and this tends to hold a higher value than qualitative or subjective data. There is a concentration on physico-chemical data and the view of diseases as entities. Mind-body dualism is a result of the categorisation process of separating mind and body. This is otherwise known as a dualistic Cartesian approach. The splitting of the psyche and soma separates them as if they have little or nothing to do with each other. Traditionally the emphasis has been on the individual patient rather than the family or community.

The patient's perspective is however steeped in subjective feeling, actually feeling ill. Illness is the word the patient uses and disease is the word the doctor uses. An individual will go to the doctor feeling ill and will come away having acquired a disease. Cassell (1976) states that illness is a patient's subjective response, and the response of those around him. Disease is something that an organ has, and one can have a disease in the absence of illness. Defining oneself as ill follows a number of subjective experiences, which might include any number of criteria *(See footnote 1).*

The over riding problem here is that the doctor will try to relate any of these symptoms to an underlying physical process, or organic malfunction in the individual. This view of 'clinical reality' assumes that biological concerns are more real, clinically significant and interesting than psychological or sociocultural issues (Kleinman et al. 1978). But the patient may want to talk about how the episode of ill health is affecting his or her life in terms of feelings, actions and behaviour. It becomes more complicated still, as western medicine itself is not homogenous, or consistent, and there are variations in treatment and management for essentially the same disease. The different approaches to clinical management are not necessarily a result of the doctor modifying treatment to the patient's needs, but as a result of the 'disease entity' being re-examined as new theories of aetiology are advanced and treatments changed, also as a result of interest and specialisation on the doctors part. This means that a patient can go to several doctors in different specialties with the same episode of ill health and be perceived and treated in different ways.

Evidence based medicine may prove to be helpful in reducing differences in treatment regimes as information through technology become increasingly available to health professionals and patients, but this in itself will not be enough. Exploration

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Footnote 1

- *Perceived changes in bodily appearance, such as loss of weight*
- *changes in skin colour, or hair falling out*
- *changes in regular bodily functions, such as urinary frequency*
- *changes in bowel habits, heavy menstrual periods or changes in respiratory or heart rates unusual bodily emissions, such as blood in urine, stools or sputum*
- *changes in function and senses, such as paralysis of limbs, tremor or clumsiness, deafness, blindness, lack of smell or taste*
- *physical symptoms, such as pain, fever, nausea or lack of appetite, tiredness and malaise. changes in emotional states including, anxiety and fear, and demonstrating labile, volatile or catatonic behaviour*
- *other behavioural changes in relation to others in or outside the home.*

and explanation of patients' health needs may come down to matching patient-professional expectations and understanding and agreement, that is *concordance*. The most satisfying method of reaching desirable states of consensus is likely to be through effective interpersonal communication.

1.3.4 Belief systems

Folklore, myths, and lay beliefs about health and illness are powerful and long-standing sources. They have remained so despite formal health services bringing the model of bio-medicine to all. Scientifically and medically we know that a virus causes the common cold; a great many lay people also know this fact. But nevertheless the English folklore of getting wet and cold as the cause of a cold remains strong and persistent (Helman 1991). This sort of comforting collective agreement somehow makes sense after all. When we get chilled and wet our body 'feels' cold, we battle with the elements, and the idea that this cold and damp can penetrate into our body causing the symptoms of a cold seems altogether reasonable given that particular set of beliefs. Experience complicates both sets of beliefs as we do not end up with a cold every time we get chilled and we don't respond to cold viruses every time by getting cold symptoms.

People bring their own explanatory models of health and disease to their doctors, as well as views about what is needed to treat them (Calnan 1988). It has already been shown that health professionals do not always have the skills to elicit patients' perceptions of their situation, or the expectations they may have in relation to treatment. Recent research graphically describes the communication problems that

parents with pre-school children have when their children are acutely ill (Kai 1996). There remains a great disparity between the parents' beliefs and expectations about illness and treatment and professionals'. Parents feel further frustrated by the inter- and intra-professionals' conflicting advice and behaviour. The advice given may conflict with their own views, but as discussion about such matters does not happen then the tensions are not resolved. There is a need for a range of accessible and specific information to support them through their own negotiation of their child's illness. Health professionals may fail to recognise parents' difficulties and frustrate them in their quest to cope with an acutely ill child in a family, as opposed to fulfilling the potential to empower them.

Peoples' own beliefs may be powerful and longstanding. The level of resistance to relinquishing deep rooted ideas and beliefs will influence whether the health professional's expertise is utilised or rejected.

1.3.5 Language

Language has been touched on but can be considered under the umbrella of socio-cultural influences. Within socio-cultural difficulties language is important enough to warrant attention as a specific category. Problems relating to the use of language have already been introduced, particularly those of scientific language or jargon failing to match and make sense to those using every day language. The problems go beyond these. If words are considered as tools or instruments, then it can be appreciated that words can be used with care or disregard. A thoughtless phrase, statement or use of words can generate more fear or anxiety in a person already feeling ill, or in pain.

Cross-cultural communication presents additional problems. Putsch (1985) makes the following observation:

> "Communication in healthcare is a complex issue. Language and cultural barriers complicate the situation. Language is the framework in which the world view of a culture is molded, and it describes the boundaries and perspectives of a cultural system. A language barrier disarms a communicant's ability to assess meanings, intent, emotions and reactions and creates a state of dependency on the individual who holds the keys to the entire process."
>
> (Putsch 1985)

The reality of multicultural healthcare is that interpreting services are variable in their availability and quality (Modood et al. 1997, Newham Healthcare NHS Trust 2003 and Commission for Race Equality 2003). Not only is there the problem of adequate interpreting services, the problem is further complicated by different ethical positions with regard to what or how clinical information is translated (GMC 1998). Cultural and religious beliefs may conflict with medical advice or treatment and the health professional is at the mercy of the interpreter to accurately translate the clinical information. It may be difficult for the interpreters if they hold the same beliefs as the patient. The following example given by Putsch (1985) illustrates that problems are not just one way as health professionals themselves can be put in positions that challenge their beliefs and values.

> "A 52-year-old Spanish-American head nurse of an ambulatory referral area in a teaching hospital frequently acted in an interpreter role. Multiple patients had confided in her regarding the folk definitions and therapy relating to their illnesses. She had consistently withheld this information from the physician staff. Over time she expressed concern about discussing traditional views and practices. "Patients shouldn't believe those things. I tell them that I don't translate what they say to doctors...If I tell the doctors, they might think I believe that too".
>
> (Putsch 1985)

The nurse in the above example could be said to be concerned with her position in the healthcare team as perceived in her eyes, which is doubtless important, over and above her patients' need to communicate effectively the cross cultural differences. A barrier such as this is not easy to overcome as long-standing beliefs and values are inevitably difficult to change.

1.4 THE DOCTOR/PATIENT RELATIONSHIP

Thus far the health professional/patient relationships has been alluded to but not explored. The focus on the doctor/patient relationship will transpire to be fundamental to many aspects of communication in healthcare from societal, institutional and individual perspectives. Of particular interest is how through numerous structural health service and professional re-organisations the power balance has stayed relatively firmly in the medical camp.

With all forms of communication there is the concept of '*relationship*' (Bateson 1972). Michael Balint, a General Practitioner in the 1950s developed a training and research approach to study and explore the doctor/patient relationship. Balint introduced psychotherapeutic thinking into the relationship (Balint 1957, 1961). There has also been significant interest in the doctor/patient relationship from a sociological perspective. Parsons (1951) carried out a now classic sociological theoretic study, which provided a model of patient behaviours and roles. Parson's work remains influential today, but further study into the sociological perspectives of the doctor/patient relationship have developed and challenged Parson's original

ideas. At this juncture it is worth considering the doctor/patient relationship in more depth from a sociological perspective.

1.4.1 Sociological perspectives on the doctor/patient relationship.

The concept of relationship between doctors and patients has some foundation in the ideas that doctors have a special place in the healthcare system and therefore can claim that they are 'special' to patients. This has been particularly associated with General Practitioners who may have, traditionally at least, enjoyed some continuity of care with individuals and families over a longer period of time (Bury 1997 pp.77-78). The sense of a special relationship is also supported by the single handedness or small practice, which allows autonomous potentially patient oriented practice as opposed to institutionalised practice often, deemed necessary in hospitals.

Sociologists have widened the term doctor/patient to lay/professional relationships (Nettleton 1995) and government and medicine are beginning to use the term health professional/patient relationship with more frequency to reflect the move towards team approaches to care and attempts to change the nature of professional power. None the less the doctor/patient relationship remains an important care issue in the every day delivery of healthcare.

> *"Though other relationships in healthcare are of growing importance, the doctor/patient relationship remains the one meeting point where, periodically for many but frequently for some, individuals encounter science and professional authority in their most developed and intimate form."*
>
> *(Bury 1997 p79)*

It will be helpful to examine the sociological perspective on the nature of the doctor/patient relationship a little further to gain insight into implications for communicative practice. Throughout the nineteen fifties through to the nineteen eighties three main models of the doctor/patient relationship have emerged from the literature. These are the consensus model, the conflict model and the negotiation model. Recent approaches to the doctor/patient relationship take a less clearly demarcated approach and begin to consider communication in the medical interaction in more depth.

1.4.2 The consensus model

This originates in the classic work of Talcott-Parsons (1951). Parsons takes a functionalist view that individuals are classified as ill when they are unable to carry out their normal every day activities and social roles. Health in this sense is therefore the pre-requisite for social action. Parsons also framed patients' responses to what might be termed, psychosocial factors, as a form of deviance. Deviance in this form is operationalised by the individual taking on a different social role from a healthy person, i.e. a 'sick role'. By opting for a sick role the individual is thereby given 'permission' to opt out of their normal every day function and become dependent on carers. The formal or professional carer, i.e. the doctor then fulfils a complimentary 'doctor role.' Each position supports and justifies the other and when these social roles are observed social conflict is avoided.

For this model to operate successfully there is a heavy reliance on the consensus that an unequal relationship is maintained. This inequality requires the patient to behave

in a compliant fashion in the original sense of the word. So, although the relationship thought of in these terms, is reciprocal it implies enduring passivity. Others have challenged this position in a changing modernised approach to healthcare. Freidson (1970) offers a conflict model as an alternative approach.

1.4.3 The conflict model

Freidson's conflict model has been influential in challenging the idea that patients are ultimately passive and compliant and argues that patients are indeed more active that Parsons accounted for. Freidson sets up the doctor/ patient relationship as a potential clash of agendas and perspectives. This approach encouraged research and interest in the patients' perspective of their illness and experience of healthcare. However, this model did little, if anything, to reduce the polemic relationship or reduce the balance of power in the doctor/patient relationship in everyday practice. The medical model is argued by Freidson to be essentially damaging and rooted in the rationale of medical knowledge and dominance. This professional authority and legitimacy holds precedence over any lay ideas and constructs of health and illness. Although patients' are concerned with the subjective experience of their illness it is the doctor's view, approach and power which prevail. The clash of agendas is not resolved.

In response to the above models and their somewhat inflexible positions Gerhardt (1987, 1989) developed a more interactional model or negotiation model.

1.4.4 Negotiation model

The negotiation model takes a more interactional perspective on medical practice and describes a sense of negotiated realities whereby exchanges will take place between an individual and others. This approach emphasises behavioural responses to illness and recognises that illness may change over time and as a result individuals responses to the illness will also change. This requires management and agreement about the illness itself and the treatment. It is a more collaborative approach and includes social context as well as functionality.

On the face of it the negotiation model would seem a reasonable base from which to develop patient centred practice which may be more inclined to meet patient's health and communication needs. It includes time and change and reduces the conflict or crisis component of the medical interaction. However, the model per se does not require a shift in power balance away from the doctor, but does insist the doctor at least acknowledges the patient's ability to manage their illness.

1.4.5 Recent approaches

Many medical encounters may at various stages include all three of the above models. Parson's view that a breakdown in the doctor/patient relationship is to do in a great part with the patient not playing the sick role adequately seems dated and patronising in a world where access to health information is becoming more accessible to a large part of any population. Freidson's work may have encouraged polemic positions, i.e. "Do you take the doctor's or the patient's side?". And negotiation implies potential conflict. Recent approaches have witnessed a decline

in inter-paradigmatic rivalry and an increase in descriptive observational search for interactional qualities, which impact on health outcomes for patients. Leanings towards a more micro approach have lead to criticism from some quarters. Scambler and Britten (2001) proffer three main criticisms. First; that there is reduced theorisation, second; the doctor/patient relationship is seen as a self contained unit of analysis thereby losing macro sociological influences, which provide context; and third; studies are typically driven by health policy.

But as it is not the job of this thesis to critique sociological analysis of health, illness and healthcare as such. It is not proposed to offer an in depth discussion but to recognise that sociological approaches have either influenced or failed to influence advances in effective communication in healthcare. Other changes in society have also influenced the doctor/patient relationship and impacted on the power and status of the medical profession. The notion of power is central to sociological and philosophical and political ideas in medicine. The changing doctor/patient relationship may provide a challenge to the balance of power, but has there is indeed been a shift in power away from the medical profession in recent years?

1.5 THE BALANCE OF POWER IN THE DOCTOR/PATIENT RELATIONSHIP

Essentially though, people consult doctors for a purpose, and that is usually because they perceive something is potentially or actually threatening the quality of their lives (Little 1995 p. 146). In other words they are seeking resources which the health professional has. The difficulty is that traditionally medical education has not

included to any great degree what the patient's understanding might involve, or more importantly how to discover such understanding. Taking a medical history is set up as an objective exercise gleaned out of the patient's narrative of his or her own subjective experience. This changes the relationship between the patient and doctor, as the patient's attention to narrative may be of little importance to the doctor who is after the list of signs and symptoms. The difference in perspective alters the nature of the relationship. The following quote by Rabin (1982) is somehow made more poignant by the fact that the patient himself was a clinician,

> "I travelled to a prestigious medical centre renowned for its experience with ALS (amyotrophic lateral sclerosis). The diagnostic and technical skills of the people were superb, and more than matched the reputation of the institution. The neurologist was rigorous in his examination and deft in reaching an unequivocal diagnosis. My disappointment stemmed from his interpersonal manner. He exhibited no interest in me as a person, and did not make even a perfunctory inquiry about my work...I still recall that the only time he seemed to come alive during our interview was when he drew the mortality curve among his collected patients for me. "Very interesting," he said "there is a break in the slope after three years".
>
> (Rabin, p.1982)

Little (1995) also highlights a tension in the doctor/patient relationship which is difficult to resolve, especially when patients are suffering from chronic or terminal illness.

> "Medicine almost inevitably involves a tension between the physicians' commitment to healing others and their economic self-interest."
>
> (Little 1993 p.151)

Additional changes have influenced the doctor/patient relationship in recent years. Although patients are generally becoming more knowledgeable and can become 'experts' in their own illness, there is still an assumption that the doctor has an

unequal access to medical knowledge. The concept of the expert patient is a recent idea (Tuckett et al. 1985, NHS Plan 2000). Access to information from a wide range of sources from media coverage to the Internet has had some effect in de-mythologising medicine and the central control doctors have had on health matters. It has been argued by some that increased access to medical information has resulted in a reduction of medical dominance (Bury and Cabe 1994). But it is not clear how Influential the dissemination of knowledge is in challenging the doctor/patient relationship on the ground. Alternative therapies are also enjoying an increased recognition and acceptance in and outside of biomedical healthcare.

Have all attempts to shift the power from doctors to other professional groups improved the patients' lot however? There is little evidence to support such a claim; and it has already been noted that the doctor/patient relationship despite its problematic nature remains a central and prime focus in the every day delivery of healthcare.

Pluralism in healthcare has undoubtedly increased over the last twenty years. Although deference to doctors is still relatively high it would seem to be decreasing. Changes in attitudes are also bound up with issues of truthfulness and trust in the doctor/patient relationship and decision making in healthcare. However many articles that can be down loaded from a web site people still want to trust doctors to help them make sense of information, to have their best interests at heart and have their right to autonomy respected. The basis of such ideas and how these have been challenged are explored in the next section.

1.6 TRUTH AND TRUST IN MEDICINE

The notions of truth and trust in medicine are not new. There is a long and traditional history in medical teachings and practice that includes information giving, withholding, concealing and lying. Hippocrates although not openly encouraging truthfulness in the quest to do no harm to patients certainly advised doctors to be secretive and conceal things from patients. So it would seem from the very beginnings of medicine as a discipline there has been overt encouragement for doctors to lie or conceal information in the aim of not harming the patient and encouraging trust and confidence in the physician. Plato generally approved of tricks and deception in order to increase patient uptake of physician advice. In his favour he did also approve of doctors who attempted to explain things or educate their patients. He viewed truthfulness and concealment as equally justified means to help restore health; a case of the means justifying the end.

In the eighteenth century John Gregory *(See footnote 2, a)* wrote about truthfulness and communication in medicine and advocated concealment and deception in doctor/patient communications.

> "A prudential regard indeed for the patients' safety may make it necessary to conceal any embarrassment or mistakes from him, lest it alarm him and lose his confidence."
>
> (McCullough p.106, 1998)

Gregory's advice for concealment and even lying extended beyond diagnosis and prognosis and included being untruthful in non-verbal communication to cover up lack of knowledge, mistakes, or to give an air of importance and gravitas at all times; presumably with the aim of leading the patient to believe they knew what was

going on. Gregory urged diffidence and composure at all times so as to reduce disquiet and reduce the likelihood of the patient or relatives doubting his knowledge and expertise.

Benjamin Rush *(See footnote 2, b)* and Thomas Percival *(See footnote 2, c)*, former students of Gregory's advised composure and cheer to encourage hope and recovery in patients, but repudiated affected pomp and lying. Lying could however be justified in exceptional circumstances in keeping with a paternalistic approach, for example around poor prognosis. Thomas Gisborne *(See footnote 2, d)* another contemporary disagreed with such ideas stating in his writings that lying was both wrong and a 'mistaken tenderness'. His advice in difficult circumstances was to say little and for that little to be truthful rather than lie. William Hooker, *(See footnote 2, e)* like Gisborne objected to doctors' benevolent lies both in principle and on the basis of his own professional experience. Gisborne suggests a way of testing whether professional hiding, concealing or lying is dishonest or a threat to the trust patients have in their doctors. His view was that if the actions can be publicised in a general way without shame, then it could be argued that peoples' trust in doctors has not been undermined. Any hiding must be done by fair and honest means.

During the first half of the twentieth century the relationship between information and individual autonomy was being explored. This was expanded from the nineteen sixties and continues to be a focus for philosophical argument and medical practice.

Richard Cabot *(See footnote 2, f)* an American physician recalled his own teaching at

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Footnote 2

Early writers on medical ethics
a) John Gregory (1725-73)
b) Benjamin Rush (1745-1813)
c) Thomas Percival (1740-1804)
d) Thomas Gisborne (1758-1846)
e) Worthington Hooker (1806-67)
f) Richard C. Cabot (1868-1939)

Harvard medical school around the turn of the century, which advised lying for patients' benefit, but not for self serving interests of the doctor. Cabot challenged this philosophy and developed a truth telling approach in his practice on two counts. Firstly that doctors are making a mistake to believe that patients do not suspect deceit when doctors are being deceitful and second that patients reactions to the truth even in difficult circumstances were not as negative as he had been led to accept (Jackson 2001 p. 19) *(see footnote 3)*.

There appear to be several issues bound up together in either the web of deceit or honesty. The first issue is the idea that patients need to know and understand their health problems in order to make autonomous decisions about them and that lying or deceiving robs them of that right. The second issue is the difficulty in ensuring that if lying or withholding information is considered appropriate in order to maintain patients' best interests then thought must be given to the wider decision making and medical contexts also. Research and treatment options would be the most graphic examples. Is the best interest position applied to groups? And if so who has the most right? The utilitarian position would uphold the sacrifice of the individual to the greater good for society in the long run. A position such as this is open to distortion, abuse and the power of vested interests. Third; to decide whether it is morally wrong to lie to patients, and fourth; the collateral damages that are sustained at the level of trust in doctor/patient relationship. The damage is done at a macro and micro level.

Footnote 3

For a comprehensive discussion on truth, trust and medicine advocating the position that doctors speak only the truth and speak with discretion see: Truth, Trust and Medicine (2001). Jennifer Jackson; Routledge: London and New York

Points three and four are turned to next. (The concept of autonomy and health will be returned to in the next chapter.)

It is widely accepted that successful doctor/patient relationships and positive health outcomes for patients are increased in an atmosphere of trust. Such trust also implies respect for both the patient and doctor which in turn implies consent and regard for individual autonomy. However, it is not until recently that autonomy has held the important position it now does in modern medicine. Indeed, as it has been shown honesty and accurate information sharing has not been part and parcel of medical education and practice. But if dishonesty threatens trust and trust is believed to be vital between doctors and patients, then how is it that such issues have been neglected for so long? There is a sense that patients, by consulting the doctor, are consenting in as far as they have sought help. This together with the tradition of paternalism and 'special relationship,' as alluded to earlier in this section, results in patients putting themselves in the hands of their doctors. After all doctors know best and have their patients' best interests at heart. Is this not the case? In the main this is so. However, there have been recent exposures of medical practice and individual doctor's actions in recent years, which have shaken society's trust and confidence in doctors and medicine as a system.

Two of the most publicised accounts have been about consent for surgery and consent for the removal of body parts which have raised issues not only about informed consent as a principle but also about the ownership of information and ultimately the patient. Who does the patient belong to in life and after death?

1.6.1 Case one

It was discovered that Alder Hey Hospital in Liverpool had carried out the practice of routinely taking infant body parts after death for storage and research purposes without informed consent from parents over a number of years (DOH 2001). When the case was investigated thousands of slides, body tissue and in some cases whole organs had been retained. Huge media coverage of the investigation, illustrated by emotional personal stories from bereaved parents, forced the medical profession to review communication practices around death, post mortem and human tissue retainment. There was a sense that the university and hospital had not learned from their mistakes and that poor management of accurate forthcoming information compounded parents and families' distress. Point 58 of the inquiry report stated:

> .. "That Alder Hey failed to make sufficient provision for face to face communication of the news of organ retention to parents. They failed to provide suitable advice, counselling and support necessary for affected families."
>
> (DOH 2001)

The professional and societal consensus around the Alder Hey experience was that doctors did not have the right to retain parts of a person no matter how microscopic without their consent. The patient is never at any stage the property or possession of the healthcare system. The utilitarian idea that research activity involving the specimens may lead to increased knowledge in the field of medicine, and therefore a greater good, was not upheld. There was also recognition that Alder Hey was not the only hospital to carry out such practice and as a result clear guidelines for informed consent in such circumstances have been recommended.

- A code of practice should be introduced to set out the required standards of practice in communications with families about hospital and coroners post mortems.

- Standardised consent forms for obtaining informed consent to hospital post mortems and any subsequent retention of tissue and organs should be provided for use throughout the NHS (DOH 2001).

1.6.2 Case two

Research is vital in the quest for knowledge and it must be recognised that research activity will impact on patient decision making and require patient participation. Randomised Controlled Trails are the stalwarts of applied medical research. The Bristol case (2001) is an example of vested interests over riding the best interest of patients. The whole case is centred around distorted communication on several levels and power bases. Parents with small babies with congenital heart disease were encouraged to give consent for their babies to undergo major heart surgery. The fact that the surgery was essentially experimental and part of a research trial was not communicated to parents. The subsequent death rates were identified in audit procedures and deemed to be unacceptably high.

The Bristol case also raises the problem of others i.e. other health professionals colluding with or exposing harmful medical practice. Healthcare is not renowned for supporting 'whistle blowers'. Individual health practitioners in Bristol were uneasy about the practice of specific doctors but did not divulge their concerns at the time. The cover up or concealment as described by the earlier authors continues to be a problem for communication in medicine (Sexton et al 2000, Mizrahi 1984). These were brought to public attention through cases like Alder Hey and Bristol.

> "Failure to put patients at the centre of care, failure of communication, lack of leadership and a 'club culture' in which people 'got on' in their careers by not rocking the boat."
>
> (Gov.uk/news 2001)

The Bristol Inquiry report (The Kennedy Report) recommended the need for involvement of patients and the public in the NHS at local and central levels.

> "....The priority for involving the public should be that their interests are embedded into all organisations and institutions concerned with the quality of performance in the NHS: in other words, the public should be 'on the inside' rather than represented as a body 'on the outside".
>
> (Kennedy Report sec. G.1 2001).

The Kennedy Report demonstrated the urgent need for a fundamental review of the relationship between government, the medical profession and patients *(see footnote 4).*

The changing nature of the doctor/patient relationship has meant that doctors no longer have the unquestioned clinical freedom but despite the recent bad press medicine still enjoys a significant degree of public trust even if the 'doctor knows best' adage has worn a little thin. Doctors have a responsibility to treat patients with respect and dignity and to work as a team with other clinical and non-clinical colleagues. Central to all of this is the notion that the patient is the focus of care and any subsequent reforms and that activity is carried out in an atmosphere of openness and honesty. Indeed the government's response to the Kennedy Report includes twenty-seven recommendations for information and communication needs of parents and patients in one chapter alone (2001).

Footnote 4

For the Governments response to The Kennedy Report please see: www.doh.gov.uk/bristolinquiryresponse (accessed February 2003).

In addition, the General Medical Council (GMC 1998, 2003) has provided guidelines and recommendations for fitness to practice, and healthcare providers have a responsibility meet the demands of increasing patient empowerment. This may be seen as an attempt to counterbalance the power in doctor/ patient relationship. The Health and Social Care Act (2001) states the requirement for patient empowerment in the modern NHS. Patients' forums and patient advocacy services will aim to increase the patient's voice in local decision making about healthcare services.

Although a welcome recognition of the essential need for effective communication in healthcare; and perhaps for the first time in the history of the NHS the needs of patients are explicitly considered over and above vested interests, there remains major problems for communication in healthcare:

- Effective communication can only be successful within the context of health professional, or specifically doctor/patient, relationships and this is in itself in a state of flux and change.

- By implication healthcare must be designed to serve the health needs of patients over and above vested interests.

- We need to agree on what constitutes health needs and effective communication.

- There are enormous implications for health professional education and training at all levels.

The doctor/patient relationship is not a 'static thing'. Relationships change in their nature, and indeed the same relationship between a patient and health professional is likely to change throughout a patient's healthcare episode. Patients who have been

seeing the same general practitioner for several years are going to have a different relationship with that doctor than the hospital specialist they are referred to for the first time. The communication needs of both will also be different.

1.7 CONCLUSION

The problems outlined, as identified from research of clinical communication in practice and the notion of the special nature of the doctor (health professional) patient relationship, have been outlined. However, perhaps it ought to be said that not all professionals have inadequate communication skills. There are skilled communicators both intuitively and as a result of training who provide support to patients and relatives, and an example to other professionals. Nevertheless enormous problems in the field of communication in healthcare remain.

To conclude, many of the problems in communication in healthcare are concerned, in the main, with professional communication awareness, understanding and skills and the reductionist approach of biomedicine. The changing nature of the doctor/patient relationship requires careful consideration along with the balance of power in this central professional relationship. A sense that patients' agendas, beliefs and ideas have been acknowledged and listened to in significant terms by doctors is important to patients and yet there is no significant evidence to show that doctors are meeting this patient need. Health professionals have an enormous responsibility in this area, which now poses them with some major challenges. Some of these challenges may be met by developing training and curricula within health professionals' education. This avenue will be explored in this work.

Effective interpersonal communication between health professionals and patients or relatives is important if the problems described in this chapter are to be minimised. However patients' do receive messages in other ways, for example, the standard of service, waiting times and environmental surroundings (Thompson 1984). A run down healthcare unit with long waiting times, poor facilities and less than good standard of service is clearly not going to inspire confidence in most patients, or support health professionals in fulfilling their roles.

Given the overall picture described in this chapter it has to be said there are a number of recurring problems that can interfere with the development of consensus between the patient and healthcare professional within healthcare. However, the search for consensus must be employed if successful patient outcomes are to be attained.

The opening quote from the Audit Commission states that services are not always developed in relation to need. The idea that we ought to agree about health needs before we can communicate effectively about them seems a common sense one, but is fraught with difficulty. The concept of need is one that is explored in the following chapter.

CHAPTER TWO

HEALTH NEEDS AND HUMAN NEED

Chapter one outlined the problem of communication in healthcare. Yet it made presuppositions about the importance of good communication in adequately meeting the need for good health care. Good communication was seen to be "a good thing" and bad communication unsatisfactory for patients and for the acceptable delivery of treatment. But why should this be so – why does effective communication and effective medical care go hand in hand? After all, for example, it might be argued that if the body is analogous to a machine and it is broken, the important thing is to fix it. What patients think or feel with regard to satisfaction with the communication – or what they might be told about in the process of diagnosing problems and dealing with them is not that crucial for success – at least so the argument goes.

This chapter will begin the process of explaining and justifying the importance of good communication in meeting health care need. It will do so initially by summarising one influential and plausible theory of human need, that of Len Doyal and Ian Gough (1991). Good communication will be shown to be a precondition for optimal need satisfaction, and optimally successful healthcare as understood in their terms. The chapter will conclude by arguing that the importance of communication for Doyal and Gough's theorisation of human need is too implied and requires greater transparency. How this should be done will be indicated, including an argument that communication is just as much a basic human need as the others that Doyal and Gough defend (chapter

4 pp. 49-75). Therefore, it must follow that good communication is just as fundamental a part of meeting health care needs as are those others that Doyal and Gough propose.

But what about approaches to health needs and how do these relate to individuals and communities? Are health needs universal needs, does everyone, everywhere have them? If so, maybe it is helpful to consider health needs within the wider context of human need. This chapter will attempt to theoretically conceptualise health needs within the wider frame of human needs. In addition, and vital to the logical development of this thesis it will be argued that communication is also a human need which has been implicated in theories of human need, but neglected as a basic human need in itself. The work on the development of a theory of human need as described by Doyal and Gough (1991) will be the main focus and theoretic argument to explore the debate.

2.1 HEALTH NEEDS

It is commonly argued that the modern biomedical model is reductionist in character. An important factor which affects communication within biomedicine is the resulting concentration on specific aetiology, leading to the neglect of environmental, economic and political influences and the social nature of patterns of disease (Little 1995 p.58). This has resulted in a care system which places value and kudos in highly technical diagnostic and curative procedures. Indeed, biomedicine has been successful in terms of cure or effective management for many diseases. The problem is, as has been shown in chapter one, that health professionals' communication skills have not grown in relation

to the growth in technology. Doctors gain much of their information from machines rather than human interaction with their patients (Doyal and Gough 1991 p. 202). Consequently, the healthcare needs of patients may be reduced to the results of an investigation. It is not surprising that one of the key papers charting the historical development of the biomedical model is titled 'The disappearance of the sick man from medical cosmology, 1770 – 1870' (Jewson 1976)

When people become ill they often need more than treatment focused only on the aetiology of a specific disease process. The "person" as well as the body must be cared for and the biomedical model is notoriously inadequate in conceputalising what such care might entail. On the one hand, effective diagnosis and treatment demand a subject and not just a body: clinical histories must be taken and treatment monitored. Neither can be done without communication with the person who is experiencing the disease process. Yet when the results of the biochemical and physiological tests administered to do both are written down, this same person vanishes and is replaced by a range of quantitative objective data that bear little relationship to the experienced reality of the resulting illness. This being said, we also know that the most effective treatment for many acute diseases remains linked to the biomedical model, (infectious diseases for example), although the same cannot necessarily be said for other chronic illnesses that resist resolution through orthodox medical care (e.g., multiple sclerosis, rheumatoid arthritis).

Because of biomedicine's successes, Doyal and Gough offer a theory of human need which uses the biomedical model rather than seeking a new one. Their approach places healthcare needs firmly in a theoretical framework of more general human need (Doyal and Gough 1991 pp. 201-204). The reason for focusing the analysis on the approach and framework offered by Doyal and Gough is that health, illness and health care are described and understood explicitly in terms that raise wider questions than those that can be reduced to the scientific measurement and analysis of primarily biological information. They argue that human needs are not only objective and universal in ways that underline the importance of the same effective health care for everyone, but that because of the nature of basic needs, this will be impossible to provide without taking the rights of persons seriously. As it will be shown this all amounts to more than just the satisfaction of physical needs as such. Doyal and Gough do not argue explicitly for the importance of good communication for the success of appropriate health care. Throughout the development of this chapter it will be shown that this can however be concluded, following the structure of the general argument that they create, along with the requirement for cultural sensitivity in achieving communicational success.

2.2 UNIVERSALITY OF NEED

Challenging fashionable post-modernist conceptions of the relativism inherent in any attempt to transcend cultural difference, Doyal and Gough argue that basic human needs are universal and not reducible to cultural difference (1991 pp. 13-16). In this sense also, their theory can be understood to be profoundly anti-reductionistic. They argue

that basic human needs are the same for everyone, everywhere. The reasons for doing so are the profoundly counter intuitive and contradictory consequences of doing otherwise.

> "The only argument to the contrary would have to contend that learning the rules of an alien culture well enough successfully to join in its activities was impossible because of the conceptual constraints imposed by one's own."
> (Doyal and Gough 1991 p. 73)

The argument for agreeing that basic needs are the same for every one every where will be supported through debate in this chapter. For example, at the most basic level one hungry child in some sense is the same as another hungry child irrespective of who or where they are. They will both feel symptoms of hunger and their survival is threatened if their need for food is not met. A similar point can be made about healthcare. One person may have angina and another may have bronchitis but in some sense they will both need what is deemed to be appropriate healthcare to help to resolve their problems. There may be a variation in terms of content and process in how their need satisfaction occurs: different medication, nursing care and so on. However, the very way in which people in all cultures employ similar discourses of need suggest a universal link between the need for health and the need for appropriate healthcare. The principle of the need for some sort of care to maintain or enhance health remains constant.

Another way in which Doyal and Gough dissect common discourse about need points toward the degree to which without an objective and universal frame of reference, it becomes impossible to avoid conflating the realms of desires and personal preference

(Doyal and Gough 1991 p 25). For example, what would a language or cultural frame of reference look like that would make it impossible to say: "I might *want* a glass of wine, but I don't *need* it. I want a new car, but I don't need that either." It would appear that everyone, everywhere must be able to distinguish between a glass of wine that if consumed might cause long-term harm rather than short term pleasure in some sense. Even if they choose to drink wine that they know may cause them some harm. Equally, if the car I have is adequate, safe and gives me the mobility that I require to make my living and look after those who depend on me, then I must be able to distinguish between my need for a car and my preference for a particular type of car. Anthropologically, one might say the same about religion. If members of a culture believe in a religion that helps to create a sense of social solidarity without consequences that are inconsistent with the interests of its members then it will be precisely in those terms that the religion will attempt to conceptualise its own justification: in terms of objective need rather than subjective preference.

In other words, the discourse of need is somehow integrally linked with the concept of necessity rather than arbitrariness. Indeed, one of the things that contemporary manifestations of consumerism are rightly criticised for is the futile blurring of the individual subjectivity of preference – often for material goods that are quite simply absurd in relation to the necessary requirements for the life and limb of those who so seek them (Sen 1985 ch 3). The universal necessity of those things that precisely are required to keep life and limb together cannot be agreed. Implicit in consumerism is the 'want principle' (Penz 1986 ch. 3). Penz describes the problems and inconsistencies in

this approach and Doyal and Gough summarise his conclusions and focus on two points.

> "First, 'want satisfaction is a principle that cannot be made measurable without additional normative judgments that are neither contained in nor entailed by the preference principle. Second, were such normative statement to be drawn up their insertion into the want satisfaction principle subverts the principle's fundamentally open ended and subjective character. Yet not to insert them in leaves it open to the problems of ignorance and irrationality."
>
> (Penz 1986 pp.132, 136 cited in Doyal and Gough 1991 p.24)

Penz argues further that 'the best candidate for additional normative judgments is some form of conception of human need'.

The following example shows how such an approach to understanding the universality of the concept of need can be applied to healthcare. One of the successes of biomedicine has been the development of immunisation programmes. The *need* for immunological protection can be argued objectively and universally. In the third world measles remains a killer disease in childhood. In the West, measles is not so likely to kill children, as they are in the main, better nourished and have higher quality living environments. None-the-less, measles is an aggressive, unpleasant infection that can result in longer-term effects on health. In any culture, immunisation is a cost-effective method of reducing death or disability. In any culture, children ought to have access to adequate immunisation against childhood diseases in order to protect them against the harm of illness or death. This is because children need, rather than want immunisation. Indeed, as both parents and health care workers know only too well, at times it is the last thing that they want.

Thus Doyal and Gough argue that indeed needs can be considered objectively in terms of outcome, or need satisfaction. Take Townsend's example of hunger. Townsend (1962) argues that even hunger is a *demonstrably relative concept and social concept... For these reasons alone the concept of absolute need deserves to be abandoned.* Townsend states this in response to attempts at applying universality and objectivity to human need, *social concepts cannot be thought of in universal terms.* Yet to pontificate about 'how hungry is hungry?' does not seem particularly helpful. Clearly at some point lack of nutrition will cause similar harm to anyone, anywhere. Were this not so, it would be difficult to conceptually differentiate between hunger and greed. Essentially hunger is not defined in terms of an empty stomach, but by what effect such hunger has on an individual's ability to flourish as an individual in some sense and how this individual will be seriously harmed if they do not get enough nutrition.

In other words, Doyal and Gough stipulate the conceptual importance of a starting point from which universal needs and culturally determined preferences can always be kept distinct. A point from which structural and procedural need satisfaction can be organised. Once need has been agreed on these terms then no more time and energy is wasted on circular arguments of need in relative terms. In doing so, they maintain their emphasis on the serious harm that will result if needs go unsatisfied, arguing that needs are:

- "...objective in that its theoretical and empirical specification is independent of individual preference, and universal in that its conception of serious harm is the same for everyone."

(Doyal and Gough 1991)

These claims have been made by others, (Plant and Lesser, 1980, Thompson, 1987, Wiggens, 1985, Sen, 1984, 1985, 1987, and Braybrooke, 1987). Braybrooke provides a needs-based approach to individual wellbeing that rests on objective and universal notions of need.

Braybrooke offers a list of human needs in two parts which include physical function and social activity. Braybrooke draws attention to the difference between social concerns and human needs *per se*. There is a significant parallel between Braybrooke's list of human needs and healthcare perspectives on need. General activities of daily living and individual health assessment tools also draw on the same approach (McDowell and Newell 1987). Braybrooke argues that lists of needs can be generated by considering what human beings must have if they are to live and function (*see chapter 2 Notes, Appendix 1, page 314*). He also considers the difficulty of fixing minimum standards of provision and resists the use of a measurement of utility, using the concept of convention instead. Within the concept of convention, Braybrooke devised a median; maxima or minima, to show how far within a reference population need is being addressed (Braybrooke 1987 pp33-45).

If Braybrooke's ideas about measuring need sound like a relative concept, rather than a universal one, is this so? Braybrooke thinks not:

"I do not think that people with the concept of needs think of them as having to be strictly universal. They are ready to find them so, and hence ready to ascribe them to everybody, sight unseen, in the present reference population. They will be ready to ascribe some needs across cultures, to any reference population that comes up. The ascription, however, is made in either case as a rebuttable

> presumption; it will not be discredited, and the standing of the corresponding needs on the list will not be shaken, by the discovery of some exceptions, so long as the exceptions in any reference population are relatively infrequent."
> (Braybrooke 1987 p.45)

Certainly Braybrooke appears to embrace universality through arguing that the precedence of need is in itself strong enough to ensure justice (Braybrooke 1987, pp.141-149). However this is clearly a problem. Many examples can be cited when convention becomes stronger than the precedence of need and be left with a situation aptly described by John Stuart-Mill As the *'despotism of custom'* (Vincent 1986 p55; Anderson 1983 pp. 45-55). To support actions and customs that in effect promote or maintain the failure of basic need satisfaction of individuals or groups within a society because it is their custom is a position, which can and should be challenged. One example might be female circumcision. This is a procedure inflicted on young girls and women in certain African cultures. It would be very difficult to defend this practice as something that is carried out for the good of the female. Many are too seriously harmed to adequately perform what are regarded as their duties even within the very cultures that advocate such circumcision, (sexual relations, childbirth).

Wiggens (1985) also goes down the road of universality and, in addition to Braybrooke, places importance on a moral and just framework to support claims of need. He describes three sorts of relativity within two senses of need; to need *absolutely* and to need *instrumentally*. The first sort of relativity is only that need involves a relation. The second is that what constitutes suffering or harm is essentially contestable; and the

third is that need may be relative to time or circumstance. Wiggens concludes that in this sense relativity is not an obstacle to objectivity:

> "Indeed making such relativities fully explicit sometimes has the effect of revealing the subject matter in question as a candidate for unqualified or absolute truth."
>
> (Wiggens 1985 p.155)

An example might be as follows: we need food both to stay alive and in order, therefore, to accomplish desired goals and flourish. To be sure, if we do not get enough food the resulting human suffering can be described in a variety of ways, both in outright physically and functionally measurable terms and in relation to the impact on not being able to achieve these desired goals. Finally, in either sense, the outcome of our poor nutrition will obviously be restricted to where and when it occurs. Analysed in this way, it can be seen that a thread of potential objectivity and universality weaves through these relativities. This is because some of the discourses employed are in themselves more universal than others (e.g. that of biological impact of starvation). The evidence of harm conceptualised in these terms suggests similarity to the point of identity whenever and wherever certain thresholds of harm are crossed.

Wiggens states that the redistribution of goods in society in accordance with need, is a more efficient approach to welfare than assigning everyone an equal share of goods. The claim of need has its strength in avoidance of harm and social justice, and endorses the conceptualisation of need as universal and objective (Wiggens 1985, pp. 167-168). These are concepts which Doyal and Gough develop in substantive terms in their theory of human need. Unlike relativists, agreement of need on a fundamental basis is sought

for any given claim. In short, we have to start and stop somewhere if we are to do anything about meeting need. Value judgments cannot be avoided completely unless we ignore differences in societies and cultures, and even then, it will be the values of the scientific method that prevail.

Doyal and Gough argue that harm *can* be defined and attempt to deal with Wiggens' statement that harm is essentially contestable by developing the notion of serious harm and allying it to individual autonomy. The concepts of autonomy and serious harm are considered in more detail next. *(Additional notes on Need – see chapter 2 Notes, Appendix 1, page 324)*

2.3 SERIOUS HARM

Doyal and Gough begin their analysis of need through accepting the argument that all need statements conform to a relational structure and the same grammar: "X needs Y in order to Y" (Barry 1965 section 5A). They argue that if a Y can be found that is clearly the same for everyone everywhere then this would make it possible to define need in universal terms. The Y they opt for is "avoidance of serious harm". Thus need-satisfaction has the avoidance of serious harm as the ultimate universal goal. In the developed world it is often the strategic pursuit of X which attracts attention. Doyal and Gough (1991) give examples of food and clothing (p. 40). In the pursuit of obtaining food and clothing it is the strategies of shopping, cooking and producing that are

focused on primarily, not the avoidance of starvation or hypothermia and social exclusion.

> "When needs are viewed as universalisable goals, the Y of the piece - the avoidance of serious harm – is often implicit and the attention of those in pursuit of their needs is focused on how to go about achieving the X."
>
> (Doyal and Gough 1991 p.40)

Doyal and Gough argue that any situation which reduces or threatens individual social participation may cause harm. Without social participation, individuals cannot learn from others how to survive and flourish in the culture in which they find themselves. Limitations of such participation for the individual entail limitations on their ability to discover who they are and what they are capable of, again within the confines of the cultural circumstances in which they find themselves. Doyal and Gough argue that it is in the interest of everyone not be seriously harmed in this sense – through sustained and disabled social participation in ones form of cultural life.

> "Another way of describing such harm concerns the impact of poor need satisfaction on the success of social participation. Unless individuals are capable of participating in some form of life without arbitrary and serious limitations being placed on what they attempt to accomplish, their potential for private and public success will remain unfulfilled – what ever the details of their actual choices."
>
> (Doyal and Gough 1991 p.50)

Individuals must be able to interact with others to learn, develop, flourish and participate in society. This notion clearly implies an important role for human communication. Converse to this, is disability, reduced autonomy, reduced social participation and increased harm. The relationship between need and harm will be

considered next. For an outline of the theory turn to *(Figure 2.a (1), p.111)*. The line diagram shows the relationship between needs and goals and the conditions necessary to support need satisfaction in order to reach the universal goals of participation in society and the freedom to choose a way of life.

The concept of a relationship between human need and serious harm is fundamental in deciding the difference between wants and needs. In the simplest terms, one can only say one needs a thing if harm or damage is a result of its lack. If people do not have adequate food then they are harmed. They suffer malnutrition and ultimately death. The basic need for food is undisputed. It is true that individuals can survive on inadequate diets but they are at risk of ill-health due to malnutrition itself, the complication of existing disease due to lack of adequate nutritional status, poor growth rates and the like. The result will be the same: an inability to engage with others socially to the degree that one otherwise would without the objective impact of malnutrition. These statements apply to everyone. Doyal and Gough thus provide a convincing argument for a universal and objective model within which one may define human needs:

> "Humans can be seriously harmed by alterable social circumstances, which can give rise to profound suffering: Social justice exists in inverse proportion to serious harm and suffering. When social change designed to minimise serious harm is accomplished in a sustained way then social progress can be said to have occurred. When the minimisation of serious harm is not achieved then the resulting social circumstances are in conflict with the objective interest of those harmed."
>
> (Doyal and Gough 1991 p.2)

To frame need in relation to serious harm in objective terms tidies up the confusion over *wants*, *needs* and *desires*. Considering need in these fundamental terms also guards against misuse of the word need. It has been argued by some (Foster 1983) that the word 'need' has been used and abused by social policy-makers. This has resulted in the idea of need being diluted and not thought of in its original profound meaning. In a sense, the word 'need' has lost its strength of meaning and at times is used as nothing more than a political slogan. By defining need in relation to serious harm Doyal and Gough avoid this pitfall.

It becomes especially important to hang on to the basic principles of need when thinking about health and healthcare. The difference between wants and needs could be the difference between life and death. An insulin-dependent diabetic may want a bar of chocolate and a pint of beer, but he most definitely does not need it. The man who comes into the cardiac clinic with end stage heart disease may want a cigarette and he certainly does not need that either. The 'need' that he feels is pathological in that it is the need to meet a harmful addiction and therefore not acceptable within the concept of human need as being considered here. Meeting addictive craving in itself is generally harmful. That is not to say that people with harmful addictions do not need help. On the contrary, it is merely that feeding addiction endangers health. Therefore, the need is not to meet the craving but to treat or manage the addiction by appropriate healthcare.

It is possible to be in need without knowledge, thereby divorcing the said *need* from any connection with *want* or *desire*. For example; the incipient nature of some conditions

leading to anaemia can go undetected for some time. A person can become more and more anaemic unbeknown to themselves. The body gets used to having less and less iron levels in the blood and the condition remains undiscovered until a very late stage. An example might be an elderly lady who presented to her General Practitioner complaining of breathlessness. She has noticed that she can't manage her daily walk to the high street without feeling out of breath and tired. She thinks this is due to her age. She prepares herself for the 'talking to' she expects from her doctor; 'what does she expect at her age?' and starts thinking in terms of having to lose her independence. Her G.P observes her pallor and fast pulse and sends her for a blood test. The result is that she has less than half the normal circulating levels of haemoglobin. On referral to hospital she is discovered to have a bleeding peptic ulcer. She is treated with medication and oral iron therapy, makes a full recovery and goes home with increased vigour to live independently. Without the appropriate healthcare this lady would suffer increased harm. She suffers on the level of health itself in purely functional terms and would be disabled socially by her functional restriction ie; not being able to go out for her daily walk. The content of the scenario will vary from example to example but the principles do not. These principles are defined objectively:

> "Serious harm itself is explicitly or implicitly understood as the significantly impaired pursuit of goals which are deemed of value to individuals. To be seriously harmed is thus to be fundamentally disabled in the pursuit of one's vision of the good. Thought in these terms, the objectivity of harm is ensured through its not being reducible to contingent subjective feelings like anxiety or sadness."
>
> (Doyal and Gough 1991 p.50)

This means that one cannot take being sad as being in need *per se*. *How* is the individual disabled? This is the question. The disablement may be due to physical or mental illness, or lack of social support. But it is not the sadness or anxiety which is the need, it is the underlying cause of the sadness.

Thompson (1987) also attempts to illustrate the difficulty of deciding whether harm is objective or subjective and considers mental state theory as well as experiential life influences before arriving at the following; '*..something harmful can deprive a person in two ways. It may actually prevent him from engaging in activities which are primary goods, or it may prevent him from appreciating the value of what he is doing without actually preventing him from doing it*' (Thompson 1987 p. 41). He goes on to say that although harm must come within the gambit of an individual's awareness; it does not follow that the individual is necessarily aware of impoverishment as a result of lack of any said good, or indeed if any other good that can replace it. The example of the anaemic lady illustrates this point. She was aware of her breathlessness and lack of energy. She was unaware that she had an easily treatable condition, which if left could have led to a serious emergency. In order to help us to understand what is harmful and what fundamental need is, according to Thompson, we must know in general terms what general types of activities and experiences are primary goods or worthwhile to a person and why (Thompson 1987 p. 44).

In avoiding serious harm it is possible to consider ourselves in a continuum to wellbeing. Objective wellbeing is independent of our desires (Platt 1980 pp. 73-84) as

desires themselves need explaining and may not be reasonable or rational. Desires are not to be confused with needs or accepted in themselves as necessary or good. Thompson (1985 p. 76) makes this point. Primary goods and needs do not have to be desired; health is one such example:

> "Wellbeing is independent of our desires; whether some event is detrimental to a persons well being depends on whether that event deprives the person of activities and experiences that are truly characterised by certain desirability predicates and does not depend on the person's desires actual or possible."
> (Thompson 1985 p.50)

According to Thompson, and Doyal and Gough, need pertains to serious harm. Despite the element of generalisability, the argument here is that generalisability does not equal relativity and even if the boundary between need and benefit is vague, to lack what one needs is worse than failing to acquire an unneeded benefit (Thompson 1985 pp. 90-97).

Doyal and Gough argue that once serious harm is thought of as demarcating needs and wants and it is accepted that it is in the interest of everyone to avoid seriously disabled social participation, the identity of basic human needs become clear. On the one hand, such disability will clearly occur in any culture if the individual is dead or seriously and symptomatically physically ill. On the other hand, social participation will also be reduced by impaired autonomy (Doyal and Gough 1991 pp. 76-80). The inability of the individual to formulate aims and beliefs relevant to their culture and to be able to act on them within the context of their potential interaction with others is reduced. Thus Doyal and Gough maintain that survival/physical health and autonomy are the two

human needs that are most basic to human flourishing and in terms of which the meaning of other more specific needs must be instrumentally understood.

2.4 SURVIVAL/PHYSICAL HEALTH

Clearly in order to interact with others successfully, one must be alive. Therefore, it follows from Doyal and Gough's analysis that no one needs anything that might kill them. While this raises an interesting question as regards certain circumstances where the individual may competently believe that life is no longer in their interest (e.g. those with end-stage motor neurone disease), it can be presumed here that all individuals do have such interests. Thus, it follows that all individuals everywhere need those things that are required to keep them alive and that since no human flourishing is possible otherwise, survival and what it takes to survive constitute the most basic human physical need.

Yet it is physical and mental health rather than mere survival that is the concern here. Being a person is more than just surviving; it is about possessing at least some degree of health and vigour to be able to go about our daily lives. There is an inextricable relationship between health and autonomy. This concept is universal and crosses all cultures. Mental illness is one example of how ill health impairs autonomy. Experience and symptoms of mental illness do differ across cultures, but comparative research has shown common cores of disabling symptoms (Doyal and Gough 1991 p. 180). Mental

illness impairs social participation in all societies and, therefore, is a threat to personal autonomy.

Doyal and Gough go on to argue that there is more to being a person than survival. This is hardly surprising since physical health is possible without there being much scope at all for social participation – their proclaimed universal interest. Therefore, they argue that survival on its own is the bottom line of the need for physical health but does not constitute a person. Their argument is *'You are surviving as a person if you are capable of intentional activity'* (Doyal and Gough p. 172) Doyal and Gough do not expand their thoughts or critique on the complex questions of individual coma, severe stroke patients or persons in vegetative states. (It is beyond the remit of this thesis to explore the moral and legal implications of these arguments). However for further reference. 'on being a person' in *(See chapter 2 Notes, Appendix 1, page 325).* Even so, given some potential philosophical difficulties it can be agreed that it is physical health rather than mere survival which is a basic human need and one which is in the interest of individuals to address before any others. Although having said that, individuals may have their survival chances endangered or altered by medical, social or economic circumstances. The quest for sensitive indices of differential survival chances goes on. The biomedical model uses mortality rates as the main indicator. But mortality rates are only useful in as far as they measure death rates. They are limited in the sense that mortality statistics do not differentiate between disease and actual cause of death. Any level of suffering up to and including death is not accounted for.

Serious physical diseases often disable sufferers from participating in society and other's expectations of them alter. For example, having a stroke might not kill you but may leave you severely disabled over the long term. A smoker is at risk of developing heart disease and/or lung cancer, either of which can kill him. This is easily measurable in terms of mortality, but his suffering is less easy to measure. Morbidity is medicine's way of encapsulating a wide variety of problems and symptoms. Morbidity, and in fact more specifically functional or structural disability, is more helpful when measuring physical health, than disease oriented or diagnostic grouping methodologies. That is not to say common themes are not valid or reliable in medical disease categories, medical causes of disability can be charted (OPCS 1988a). It is merely that they will not mean the same to all. What is it about the disease which restricts the individual's ability to participate is important, not necessarily the disease itself. Stroke is a good example of this point. A woman has a stroke and is left with hemiplegia and dysarthria; what disables her the most? So morbidity data as well as mortality data, as they stand, have drawbacks:

> "The former *{mortality}* is influenced by levels of provision, monetary and non-monetary factors affecting access, and many other factors. The latter *{morbidity}* will be subject to cultural influences and the other problems bedeviling subjective appraisal of health. While we have ruled out subjective assessment as a decisive measure of ill-health, it does not follow that self perception is irrelevant when combined with other indicators." *{my italics}*
>
> (Doyal and Gough 1991 p.178)

The Biomedical model embraces these views and includes categories of impairment, disability and handicap (WHO 1980). Ten main areas of disability are considered: Locomotion, reaching and stretching, dexterity, seeing, hearing, personal care,

continence, communication (being understood and understanding others), behaviour, and intellectual functioning (memory, clarity of thought processes) (OPCS 1988a. p.10). Biomedicine is agreed to be the most universally applied model by the central international organisations concerned with health promotion (e.g. World Health Organisation). To sum up, Doyal and Gough state:

> "In short, physical health can be thought of transculturally in a negative way. If you wish to lead an active and successful life in your own terms, it is in your objective interest to satisfy your basic needs and to optimise your life expectancy and avoid serious physical disease and illness as conceptualised in biomedical terms. This applies to everyone, everywhere."
>
> (Doyal and Gough 1991 p.59)

So, irrespective of culture, an individual in Britain who has, for example, bacterial pneumonia, will be similar to an individual in Bangladesh who has pneumonia. They will both feel ill, they will both suffer some degree of restriction of participative life due to illness. And in the case of the disease both will require curative measures, of which antibacterial therapy is likely to be most successful. Culturally there may be different modifications to the environment to facilitate recovery 'alongside' the biomedical cure. That is to say the Briton may require adequate heating and the Bangladeshi may require cooling. Essentially, any activity to promote need satisfaction will have to agree with the principles that inform the biomedical diagnosis and treatment, if a successful outcome is to be attained. Individuals will need universally to have some level of understanding and cognitive skill to meet the need for optimum health. (An individual with severe perceptual or learning difficulties will require representation of agency or advocacy).

2.5 AUTONOMY AS A BASIC NEED

It will be recalled that for Doyal and Gough, the universal interest and therefore goal, which can be presumed to apply to everyone anywhere is the avoidance of serious harm which results in seriously disabled social participation. If these goals are met through the necessary material inputs, then individuals have the opportunity to increase their potential for human flourishing within their cultural environment. Autonomy is considered to consist of more than just being in control of oneself. This aspect of autonomy is called 'autonomy of agency'. Autonomy of agency can be said to be autonomy in the minimal sense. That is: '*To have the ability to make informed choices about what should be done and how to go about doing it.*' (Doyal and Gough 1991 p. 53).

Yet, however minimal it is, the importance of autonomy of agency and participation in one's form of cultural life presupposes more than just a behaviouristic response to others. Such participation is essentially intentional in character rather than automatically reflexive. Persons consist of more than the bodies that literally give material substance to their personal identities. Whoever and wherever they are, they must be able to develop appropriate beliefs and formulate the goals that they wish to try to achieve in order to make such achievement a practical possibility. Minimally, this will entail both either learned and understood strategies relevant to this achievement or, at least, the cognitive and emotional potential for such learning and understanding.

It should also be noted that the ability to conceputalise and to plan for the future is made possible by autonomy of agency. The ability and freedom to formulate and implement appropriate aims and beliefs goes to the heart of our belief that individuals can exercise freedom of choice. The possession of such choice presupposes the ability to envisage alternative strategic possibilities in life and the means by which these alternatives may be realised. Equally, the imputation of moral responsibility on individuals for their choices also must presuppose the coherence of the concept of autonomy of agency. Without the ability to formulate alternative goals, there could be no choice between them and thereby nothing for which individual actors could be blamed if they act unreasonably, or applauded for if they act reasonably (Doyal and Harris 1986 ch. 3). Autonomy in this sense is to do with how we decide and separate individuality and identity as one person from another (Parfitt 1984 part 111).

2.5.1 Critical autonomy

Autonomy is to do with having a degree of direct or indirect control over one's life. However, one might be able to exercise such control within a given normative framework – in its broadest form a given cultural form of life – and still be denied fundamental choices and control over crucially important aspects of one's life. According to Doyal and Gough, the point at which individuals are able to move beyond such denial and make choices that are independent of the primary cultural framework(s) within which they mostly interact will mark the point that their autonomy becomes "critical" rather than just an autonomy of agency.

"Where the opportunity exists to question and to participate in *agreeing* or *changing* the rules of a culture, it will be possible for actors significantly to increase their autonomy through a spectrum of choices unavailable to the politically oppressed. In such circumstances, actions which hitherto they could only be said to choose through interpreting the already existing rules of their particular social environment, become chosen and their own in a much more profound sense. What was autonomy becomes 'critical autonomy'."

(Doyal and Gough 1991 p.67)

Just as there is more to physical health than survival, there is more to the cognitive aspects of autonomy than culturally specific skills. Doyal and Gough take pains to discuss the necessity for educational opportunities to learn about alternatives, that is to say, other cultures. Cross cultural learning provides the linguistic and practical skills and offers the chance to understand conceptually and to make a real choice of a normative environment. Without a robust cross-cultural learning experience this element of choice is denied.

A graphic example of violation of this principle is the case of female circumcision in parts of Africa and the East as previously mentioned. In fact this example violates all of the components of individual autonomy. Physical and mental health are threatened, the process of childbirth is made yet more dangerous, as well as the opportunity for satisfying sex. And if this is not harm enough, the girl has no choice in the matter. Even if in some formal sense she did choose to be circumcised, so long as the choice was not informed in relation to other cultural alternatives and she was not given any realistic alternative, the choice would remain potentially harmful. For aside from the harms already referred to, her circumcision might create personal problems for her in

interacting in new cultural contexts where her physical injuries would be inhibiting. Less dramatically, the same can be said of any form of tribal scarring.

In order for individuals to have critical autonomy, they must already have reached significant levels of freedom of agency with relatively high levels of understanding and capacity for reflective thought and interpretation of presented ideas. It is not surprising that those who do struggle for the freedom for cultural mobility, including the ability politically to challenge existing cultural values, commonly score high in relation to their understanding, mental health and social opportunity. For example, Barrington-Moore (1978 ch. 3) suggests that this explains why effective political protesters are often from surprisingly well off socio-economic backgrounds.

It is for these reasons that Doyal and Gough give three main factors or variables that effect an individual's level of autonomy. These are: understanding, mental health and opportunities. Let us be sure about why these factors are important. Each will now be outlined.

2.5.2 Understanding and cognitive skills

The ability and opportunity to learn and develop cognitive skills is a component part of autonomy. Many of these skills are basic to all cultures, and include language and motor skills. Doyal and Gough introduce the necessity of language and its relationship with understanding and personal autonomy.

"It is generally accepted by educationalists that self conception and the potential for intellectual growth go hand in hand with fluency of language use. The world does not present itself through experience which is already, as it were, conceptually prepackaged. Order and understanding must be imposed via the medium of language. For this reason, the richness of someone's language is influenced by, and in turn, influences, the extent and variety of their world, along with what they can and cannot successfully do within it. The cognitive dimension of autonomy expands in relation to linguistic proficiency."

(Doyal and Gough 1991 pp.181-184)

Successful participation in any given culture will require particular combinations of cognitive and associated linguistic skills. Some will focus on the successful execution of practical, everyday activity. Others will be more abstract and will involve an understanding of the symbolism used by the culture to draw its identifying boundaries. Thus, in the context of particular social roles, some successful participants must understand how to grow certain types of food, for example, and positively indicate their belief in certain kinds of religious beliefs. The success of participation – and to this degree human flourishing – will depend upon the degree of both types of such understanding.

2.5.3 Mental health

Individuals may have highly developed cognitive skills and still be unable to successfully participate in their form of cultural life. Examples such as types of schizophrenia, memory loss, Alzheimer's disease and psychotic depression seriously affect an individual's sense of self and perception of the world around them, and how they interact with it. With this in mind, as with their use of the concept of physical

illness, Doyal and Gough provide a negative definition of mental illness – the absence of psychiatric disease – and in the process attach their views to clinical orthodoxy.

This approach is in keeping with Doyal and Gough's views on relativity in the definition of need; and the need for congruence with the biomedical model with regard to the classification of disease. They do not use the term mental disease unless the physical pathology of the illness has been identified. Therefore, terms such as distress or well being are avoided. They cannot be used in the structure of Doyal and Gough's argument. This means that alternative powerful theories of mental health and illness are not drawn on, but are acknowledged as important, especially with regard to cultural differences. Others have questioned the very existence of mental illness (Szasz 1961) or challenge western medical orthodoxy as an approach (Hirst and Wooley 1982).

However, in support of Doyal and Gough's approach and in addition, it has been argued by others that revisionist theories in their attempts to reduce the concept of mental illness have made it more difficult to reform mental health services. To this end attempts to enlighten psychiatry and the public could be argued to be highly problematic (Sedgwick 1982 p.41 cited in Fulford 1989 ch. 10). Doyal and Gough focus on serious mental illness where even if the aetiology is in doubt, there is significant impairment of social participation and a significant reduction in individual autonomy (Doyal and Gough 1991 pp. 61 – 63).

2.5.4 Opportunity to participate

Doyal and Gough argue that human autonomy entails the opportunity to participate in some form of meaningful activity and that to be denied the capacity for potentially successful social participation is to be denied humanity. Haworth (1986 ch.6) agrees with this position and argued that individuals who are denied a significant range of opportunities will as a result also have their freedom and autonomy reduced. They are, therefore, less able to explore their potential as people. It is simply not sufficient to be sound of mind and body. To be disabled through lack of opportunity to realise these capacities directly threatens autonomy. Indeed, in the same vein, Doyal has argued elsewhere that: *"Individuals must have the opportunity to express both freedom of agency and political freedom. Without both types of opportunity, they will again be effectively disabled, even though their levels of understanding and cognitive and emotional competence may be quite high."* (Doyal 1990 p. 1-13). For example, to imprison someone will inevitably restrict their autonomy no matter how physically healthy and educated they may be. Without opportunity actors with high levels of cognitive and emotional understanding will be objectively disabled.

Of course, when Doyal and Gough refer to the constraint of social opportunities in relation to constraints on autonomy, they do not mean all opportunities. Only those associated with the satisfaction of basic needs themselves are of primary importance. They mean opportunities: "*..which the actor deems significant for the rational improvement of her participation in her form of life. This means that when we link*

improvements in autonomy to increased choices, we do not mean any old choices." (Doyal and Gough 1991 p. 66). For example, the sort of opportunity that is being referred to here is not of the sort that one associates with different brands of the same type of consumer goods in supermarkets but that which is required for social interaction relating to key cultural activity (e.g. religion).

2.5.5 Intermediate needs

So far, it has been shown that Doyal and Gough argue that survival/physical health and autonomy are the basic human need of all people and explained why they hold this view. However, it is one thing to argue for the universality of such needs in the abstract terms that have been outlined. It is quite another to show how these needs can be materially satisfied in ways that do not collapse into the very cultural relativity that Doyal and Gough are trying to overcome. To do so, they must find a way to maintain the discourse of need satisfaction on the same level of universality as need definition. It is in order to accomplish this goal that they develop the concept of intermediate needs.

They begin with the concept of universal satisfier characteristics: *"those properties of goods, services, activities and relationships which enhance physical health and human autonomy in all cultures."* (Doyal and Gough 1991 ch. 10 pp.191 – 221) They use the example of calorific intake as an example. A minimal level of such intake is required to stay alive, much less to flourish, in all cultures of whatever kind (Doyal and Gough 1991 pp.194-196). Similar points can be made about what constitutes shelter that

satisfies basic need to a minimal extent. Doyal and Gough refer to such universal satisfier characteristics as intermediate needs – those needs which must be satisfied if the basic needs for physical health and autonomy are to be satisfied. This concept enables a bridge to be built between the universality of intermediate needs thought of in these terms and the cultural relativity of particular satisfiers of such needs (e.g. not calorific intake but rice and beans with a specific measurable calorific intake).

Doyal and Gough argue that there are eleven intermediate needs (Doyal and Gough 1991 pp.194 –218):

- Nutritional food and clean water

Long term malnutrition when caused by a lack of specific nutrients cause a variety of diseases which impact on our need and ability to communicate. Vitamin A deficiency causes blindness, vitamin B deficiency causes beri beri and pellagra, iodine deficiency is associated with mental retardation or learning difficulties, hearing and speech and neuro-motor function. Lack of clean water causes suffering and death in millions of people through water borne and parasitic diseases. These affect mainly babies and young children in the developing world.

- Protective housing

Protective housing needs to protect against four main criteria; climatic extremes, pests and disease carrying vectors, provide adequate sanitation and appropriate heating and insulation (Doyal and Gough p.196). Poor housing especially when associated with

overcrowding leads to illness and disease such as slow cognitive and physical development in children and stress and depression in adults (Douglas 1983). Poor sanitation encourages the spread of bacterial and parasitic diseases such as Trachoma which causes blindness.

- A non hazardous work environment

Working conditions can inflict occupational illness or disability, which directly effect a person's ability to communicate. Shift workers are much less likely to hold positions in various organisations including political parties, parent-teacher associations and so forth. They have fewer friends and even contact with their own family can be reduced to inconvienient or unusual times of the day (Walker 1985). Work place design can have a detrimental effect on workers need to communicate with each other and with superiors. Oldham and Brass (1979) demonstrated that an open plan office with low-rise partitions gave rise to decreased job satisfaction, reduced ability to concentrate and reduced feedback from supervisors. The social impact included a decline in work related friendships and a reduced opportunity for privacy and interpersonal communication. Work related stress and depression is an increasingly recognised issue in modern employment. Other studies have shown a detrimental relationship between low affective well being at work and family relationships (Piotrowski 1978). Negative features at work reduces the workers emotional and interpersonal availability at home. This detailed observational study describes behaviours which demonstrate non-responsiveness, irritability and disengagement from the family. Negative consequences such as this are harmful to family life, especially if young children are involved.

- A non hazardous physical environment

A non hazardous environment in Doyal and Gough's terms relates to incidences over and above sanitation, housing and working conditions. Disasters such as major industrial accidents which endanger communities and pollute the environment. Pollutants such as lead and mercury are known to have adverse neurological effects. Minimum safe levels for pollutants are laid down by the United Nations and other agencies.

- Appropriate healthcare

Appropriate healthcare is the intermediate need which is explored in depth throughout this thesis. What such health care insures is that when disease occurs for whatever reason and the disabilities that it creates can be mitigated by medical intervention, then such disability will be minimised.

- Security in childhood

There is little argument that in all cultures children need safety and security. That is not to say that children across the globe live safe and secure lives. Children are also valued differently in cultures. Which ever care system the child is in, be it a family or welfare, the child will require love affirmation and positive role models to in order to develop effective communication and social skills. Children need to be loved, praised, guided, protected from dangers and educated so that they may become autonomous healthy flourishing individuals. They also need these things so that they can develop communicatively, to act on the world and be heard, to share ideas and beliefs.

- Significant primary relationships

Significant primary relationships are closely linked to the intermediate need for security for children. Most adults need close loving relationships, partners, friends and family to share thoughts, feelings, aspirations and concerns. When we do not have these, in times of relationship breakdowns or death, then it is common for people to become more likely to develop depression or other mental illness. Private and supportive relationships, no matter how difficult to maintain, underpin wider societies in all cultures. In times of need and distress we turn to our significant others because we need our distress to be communicated, acknowledged, validated and related back to us in ways which are meaningful to us personally. A main function of relationships is that of meeting the basic human need to communicate.

- Physical security

Any sort of terrorist, political or criminal acts which prevent individuals from implementing choices about basic need satisfaction will in itself be an impediment to such satisfaction. Solitary confinement as a form of punishment reduces the prisoners patterns of social interaction to those which are allowed under the strict rules of their jailors. The ability to express ideas, beliefs and concerns is denied and further more is considered non valid. The ultimate infringement is to kill another to prevent them from interacting with anyone.

- Economic security

Those in society for whom economic security is absent; the poor, unemployed, homeless, disabled, aged or otherwise vulnerable do not have a strong voice in society. Poverty reduces leisure and social pursuits in modern societies, and with this opportunities for social interaction. The insecurity brought about by such poverty can be disabling and thus can exclude individuals from social participation in the main stream of their culture.

- Appropriate education

Education is more than the formal acquisition of knowledge. In its broadest sense education entails the cognitive, emotional, spiritual and social development of each individual throughout their lives. Teachers of whatever kind have the capacity to engender in others the skills required to participate socially with any degree of success. This said, Doyal and Gough do not underestimate the importance of the appropriate formal education as a pre-requisite for the enhancement of personal autonomy. This will include basic literacy and numeracy skills, along with an understanding of the basic norms and laws of the individual's culture, along with an ability to communicate with others over a wide range of subjects, contents and contexts.

- Safe birth control and child bearing

In light of what has been said about the relevance of the other intermediate need satisfiers for the satisfaction of the basic needs for health and autonomy, the inclusion of safe birth control and child bearing as an intermediate need should be clear. On the

one hand, a vast literature indicates that both the survival/physical health of women are compromised without them (Doyal and Gough 1991 pp.217-218). On the other hand there is good evidence to support the claims that sexuality and sexual function are an important part of successful adult relationships (Tiefer 1996, Bancroft 2002).

2.6 SOCIETAL PRECONDITIONS AND INTERMEDIATE NEEDS

Thus far Doyal and Gough have argued that health and autonomy are universal basic human needs; why they maintain that the satisfaction of these needs will be in proportion to the satisfaction of universal needs through specific intermediate needs; why these intermediate needs can in themselves be successfully satisfied in a variety of cultural ways and why individuals may have high levels of autonomy of agency, but low levels of critical autonomy. Clearly, the satisfaction of the basic needs of any individual must take place in a social context. Goods and services necessary for this satisfaction must be produced by others and relevant skills must be learned from others. Individuals cannot create for themselves the basis on which intermediate need satisfaction can be organised. Therefore, Doyal and Gough argue that for this social context of need satisfaction to function successfully, a series of societal preconditions must be met (Doyal and Gough 1991 ch 11 pp. 222 – 246). These include negative and positive freedoms, these are; the freedom to act and interact without arbitrary interference from others; and the material, educational and emotional inputs required to do so (Berlin 1969). Negative freedom is not in itself enough to encourage individual autonomy, (Doyal and Gough 1991 p.78). We would not learn how to participate

successfully in society, thereby being disabled and reduce our capacity to become a fully autonomous person. Positive freedom is required and entails direct and relevant support as regards the satisfaction of all of the intermediate needs that have been outlined.

Doyal and Gough argue that there are four universal social preconditions for successful need satisfaction to occur. These reflect effective systems of production, reproduction, cultural transmission and political authority. Others have argued similarly (Braybrooke 1987 pp. 48-50.)

Healthcare provides a good example of what they are getting at. Individuals cannot provide formal healthcare over which they do not have direct control for themselves. They depend on access to some sort of effective delivery system. Thus, in healthcare in Britain, the right exists to health care provided by the National Health Service, which is free at the point of delivery. This would be impossible unless health care was socially organised so that it could be produced for this purpose. This will only be possible through material wealth generated though appropriate economic production, through the reproduction of adequate personnel and through the transmission of knowledge and skills to sustain it over time. All of this is exercised through the political power required for successful management.

Figure 2.a shows the relationship between the basic need for health and autonomy, intermediate needs and societal preconditions.

Figure 2.a (1)
(Adapted from Doyal and Gough 1991)

Set in these terms, it may be easier to understand the theory as a form of hierarchy. Society needs organised healthcare to provide the environment in which appropriate healthcare processes and outcomes can be aimed for. These processes and outcomes in turn ought to have the overall aim of maintaining, enhancing or increasing individual health and autonomy as the core goals. With such reasoning, Doyal and Gough have attempted to delve yet deeper into the question of human need by considering what sort of societies are most likely to be able to meet basic needs through the satisfaction of intermediate needs. The only criterion for inclusion in Doyal and Gough's list of such needs is that each set of satisfiers universally and positively contribute to the satisfaction of physical health and autonomy as basic needs (Doyal and Gough 1991 p.157-158).

To further illustrate, let us return to the universal interest that, according to Doyal and Gough, all humans have in common. Thus in the previous example of our anaemic lady, it was suggested that the problem with her anaemia was the degree to which it disabled her social participation. To avoid restricting or disabling people from participating fully in their society structures and processes must be in place to ensure avoidance of serious harm in these terms. These structures and processes will need to be at the highest levels and filter down through to the individual. They will include governmental policies at national and local levels, all pertaining to education, healthcare, housing and other welfare agencies. See Outline of Theory of Human Need *(Figure 2.b, page 113).*

The following outline shows the relationship between all of the components of Doyal and Gough's theory as outlined so far.

Theory of Human Need

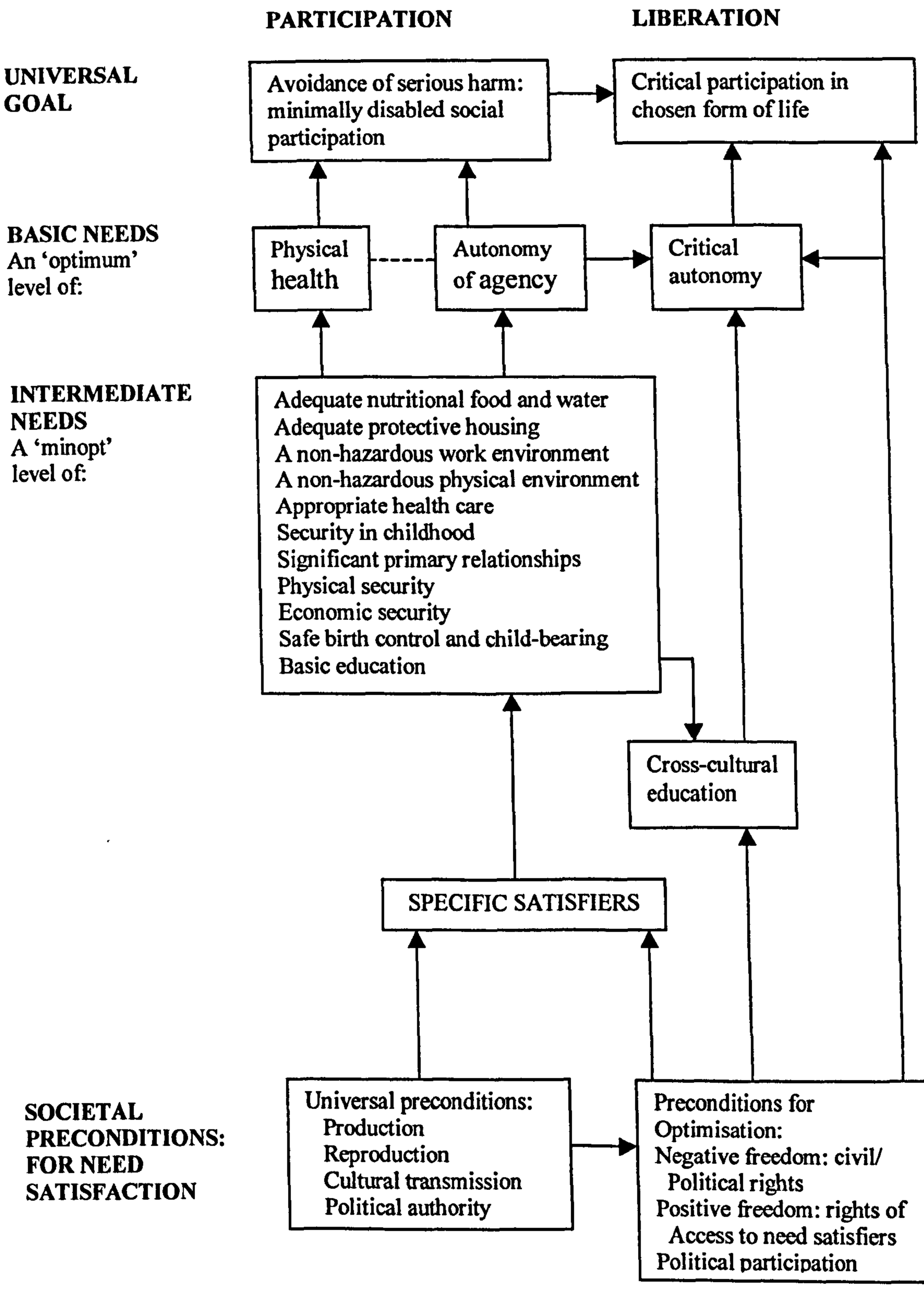

Figure 2.b Outline of Theory of Human Need
Doyal and Gough (1991 p.170)

2.7 RIGHTS AND NEEDS

If it is accepted that Doyal and Gough have got it right and that human need should be conceptualised in the ways in which they argue, would such an assumption close the door to relativism – the problem that led to their conceptualisation in the first place? On the face of it the answer is "no". It may well be the case that survival/health and autonomy are basic needs and that we now understand what is required in principle for their satisfaction. However, it does not follow that these needs *should* be satisfied for everyone or anyone. To this degree one may still argue that just because someone is needy does not entail the obligation to satisfy that need. Why not believe that it is morally acceptable to decide whether or not to support societal structures and processes (e.g. through taxation), designed to deliver at least a minimal level of need satisfaction? Why not equally argue that no culture should dictate to another not who needs what but whose needs should be satisfied and to what degree (e.g. through depriving women equal access to education)?

The discourse most suited to counter such relativism is that of universal rights. Such discourse focuses on the concept of entitlement. That is, morally justified claims that all individuals may make on each other. Claims of this kind become correlated with universal duties. Property rights and the right to appropriate health care provide good examples. Where such rights exist, individuals may expect others to honour them – to respect their property though not arbitrarily inflicting damage upon it; and to provide them with access to appropriate healthcare when and if they may need it in identifiable

ways which are themselves deemed to be appropriate. Thinking about need in terms of rights implies both duties and responsibilities. To the degree that rights are believed to be associated with need satisfaction, it follows that the need in question ought to be met either by the individual or the wider society.

Again however, it does not follow that a moral obligation necessarily carries with it a duty on the part of all individuals immediately to satisfy all of the needs they encounter. For example, if you come across a beggar in the street you might agree that there is a moral obligation to provide food, shelter and safety but that you do not have a personal duty to provide it in the immediate sense. Thus, you may not feel inclined, or have the ability to take him into your home or personally provide for him. But if you believe in his right to need satisfaction in basic and universal terms then it will be the case that you have an obligation to provide material support for social organizations and agencies required to distribute responsibility for need satisfaction among everyone.

> "Not only does social life require moral responsibility; the same can be said for the success of our own participation within it. Unless we happen fortuitously to have the power to inflict our will on others, social success will depend on our capacity to understand what our moral obligations are and our willingness to act accordingly."
>
> (Doyal and Gough 1991 p.92)

The argument for thinking of human need in terms of rights has been strengthened further by Human Rights legislation across the world, the United Nations Declaration of Human Rights (1948), the Declaration of the Rights of the Child (1959), and The European Convention of Human Rights (1963). A list of some 40 separate rights

provided by Humana (1986) and the Human Rights Act (1998) exists. All of these focus on the importance of satisfying Doyal and Gough's intermediate needs which are accepted as both objective and universal.

But yet again, the statement of such international moral commitments does not itself constitute a moral justification for them. In order to provide this, Doyal and Gough argue that a moral commitment to universal need satisfaction logically follows from the fact that all cultures embody other clearly defined moral commitments on the part of their members. Doyal and Gough refer to the latter as "visions of the moral good" (Doyal and Gough 1991 pp.99 – 102). If members of cultures do not do their best to live in accordance with such visions – (e.g. religious) then they may be deemed morally defective as regards the moral code of the culture. They will not be regarded, so to speak, as good citizens of the culture. Doyal and Gough stress that what is deemed to be 'best' or 'optimum' will vary between cultures, depending on their particular moral codes and resources.

> "Our point is rather that the members of specific cultures will already have reasonably clear ideas of what doing one's best amounts to *in practice*. These will be linked to exemplars of what ordinary individuals can hope to achieve if they apply themselves to the best of their ability, along with theories about the levels of health, learning and emotional confidence which are usually associated with such application."
>
> (Doyal and Gough 1991 p.100)

Doyal and Gough argue that regulators of cultural norms and laws cannot have it both ways. Demanding that the vision of the good of the culture is actively embraced by its members but not at the same time ensuring that these same members have their own

basic needs satisfied and the resources required to discharge a commitment to satisfy the needs of others is problematic. *"Ought implies can"*. To say that someone ought to do something entails that they have the practical wherewithal to do it. Therefore, if it is expected that other members of my culture do their best to do what is believed to be right, then they must be able to deliver. They will not be able to unless they have the survival/physical health and autonomy required to do so. But this must mean that they should be regarded as having a moral claim on the necessary intermediate need satisfaction for survival/health and autonomy to be a real possibility. And this in turn means that those who expect others to be good moral citizens in their terms must, to be consistent, believe that they have a moral right to such intermediate need satisfaction.

According to Doyal and Gough, the same argument applies to everyone else as well. If I really believe that my cultural vision of the moral good is correct then it follows that I want everyone to believe and act in ways consistent with this vision – whoever and wherever they are. This belief does not just entail a desire for physical conformity to my vision – the sort that might be associated with slavery. Rather, the demand is for others to *choose* to be good moral citizens in my terms; to consider and accept my moral vision with both deliberation and competence. It has just been argued that this will again demand appropriate levels of need satisfaction everywhere. For example, it is morally meaningless for Christians or Muslims to hope for the conversion of others outside their culture unless they believe that they should have a real opportunity to make the welcome choices. However, such choice will only be employed in the light of appropriate levels of need satisfaction wherever they are expected.

It is for this reason that Doyal and Gough argue that real commitment to a vision of the good has international moral consequences as well as those associated within the particular cultural boundaries. "*Two points are worth making. First, there is a firm moral case for a global conception of need and in just ways of meeting need...second... Optimising need satisfaction on a world scale ultimately entails some system of global authority to enforce global rights to need satisfaction*" (Doyal and Gough 1991 p. 294). In short, if it is to be believed that this position is morally right and that all others should strive to be the same on these terms, the conviction must carry with it a commitment to the basic need satisfaction of everyone everywhere – of the very basic human rights endorsed by various international agencies. In so arguing, Doyal and Gough commit themselves to a strong world government and the implementation in the developed world of a "needs tax" in relation to the requirements of those in the developing world. Like national welfare agencies Doyal and Gough state there is the same obligation internationally (Doyal and Gough 1991 p.107). A similar point has been made by others (Goodin 1985 pp.163–7). International agencies could be financed through a system of taxation. However how this might be organised and delivered is not discussed within Doyal and Gough's theory. The notion is proffered as a logical progression of their argument. If basic needs are the same for every one every where, then surely international need satisfaction on agreed terms should be aimed for.

Elsewhere Doyal (1995) provides a practical illustration within health care of the moral logic exhibited in the preceding arguments. Clinicians themselves have strong beliefs about the moral obligations of their patients. Specifically, they usually believe that

patients should do their best to adhere to appropriate regimes of treatment and not waste precious NHS resources. Yet, as Doyal points out, this expectation is hollow without a corresponding belief in the right of patients to have their basic need for autonomy reinforced through the satisfaction of relevant intermediate needs. For example, it makes no sense to expect patients to adhere to treatment unless they have been appropriately educated about why doing so is in their best interest. This is why they have a right to such education and, because it reinforces this right, a right to informed consent to treatment. The increasing globalisation of appropriate health care underlines how this same argument can be applied internationally. Indeed, it is precisely the existence of such rights that is endorsed by the World Health Organisation (1987).

2.8 WHERE DOES ALL THIS LEAD US? AND WHAT PROBLEMS REMAIN?

Acknowledging the need for appropriate healthcare is all well and good, but how that aim is reached is not just dependent on medical knowledge, evidence-based practice and clinical trials, but communicative action. The fact that health and autonomy is not dependent on healthcare alone has already been stressed. This is now undisputed (Illich 1972, McKewon 1976). But healthcare remains a significant part in the equation of health.

There are difficulties when attempting to take the phrase “serious harm” out of the abstract and to define it in concrete terms. Humans are essentially social beings and this includes environments that are wider than "non-hazardous", and relationships that

involve more than "security". Doyal and Gough do not say otherwise, but pleasure and leisure are not considered as anything other than extras. The sayings; "All work and no play," or "a little of what you fancy does you good." come to mind. This is not meant as a trivial criticism, as pleasurable activity and contacts are health enhancing as well as providing balance and relief in day-to-day living. Soper (1992) made a similar point in her comprehensive critique of Doyle and Gough's theory.

It is also unclear when discussing degrees of autonomy how the level of critical autonomy can be considered a basic need when the pre-societal requirements to maintain this level of autonomy are so elaborate and sophisticated. Critical autonomy seems more allied to a higher need. Also, in simple terms, some individuals will not reach levels of critical autonomy by virtue of their own intellectual, physical or mental capacities, even in optimum societal pre-conditions. 'Fully flourishing' as a term must mean the opportunity to reach potential at what ever level possible for any individual. Freedom of agency, however, is almost indisputable as a human right for a rational being. That is not to say a society that aims for its members to reach critical levels of autonomy is not preferable, applauded as good, and morally superior to a neighbouring society that does not, all things being equal. Sen (1985) raises this question in terms of rights and capabilities, he argues that essentially there is moral legitimacy to the claim to positive and negative freedom.

> "The rights in question are not concerned with my actual capability of doing this or that, but my freedom to do them without let or hindrance."
>
> (Sen 1985 pp.130-148)

Doyal and Gough, provide a strong argument for society to take positive action by offering a framework of societal pre-conditions to enable basic need satisfaction in terms of rights, or indeed claims.

Appropriate healthcare is also open to debate and is notoriously difficult to manage, due to resulting conflict over decision making on several levels. The term 'appropriate healthcare' is not developed within Doyal and Gough's theory, so it is not clear what is meant by appropriate, other than it will sit within the biomedical model. Doyal and Gough do not elaborate on the patients contribution to consultations or the types of communications that will be most helpful in meeting the needs of patients.

The need satisfaction of appropriate healthcare however, requires both the patient and health professional perspective and this has been shown to be a longstanding problem in medicine and most specifically the doctor/patient relationship *(chapter 1, section 1.4 pages 57-62)*. Moreover and importantly, communication is an implied intermediate need satisfier to meet the basic needs of health and autonomy within Doyal and Gough's theory as it stands. At this point it would be helpful to return to the fundamental question of basic needs and discuss whether this is incontrovertible, or whether communication can be argued as a basic human need alongside health and autonomy. If the latter is the case then Doyal and Gough's model would look like *Figure 2.a (2), page 122).*

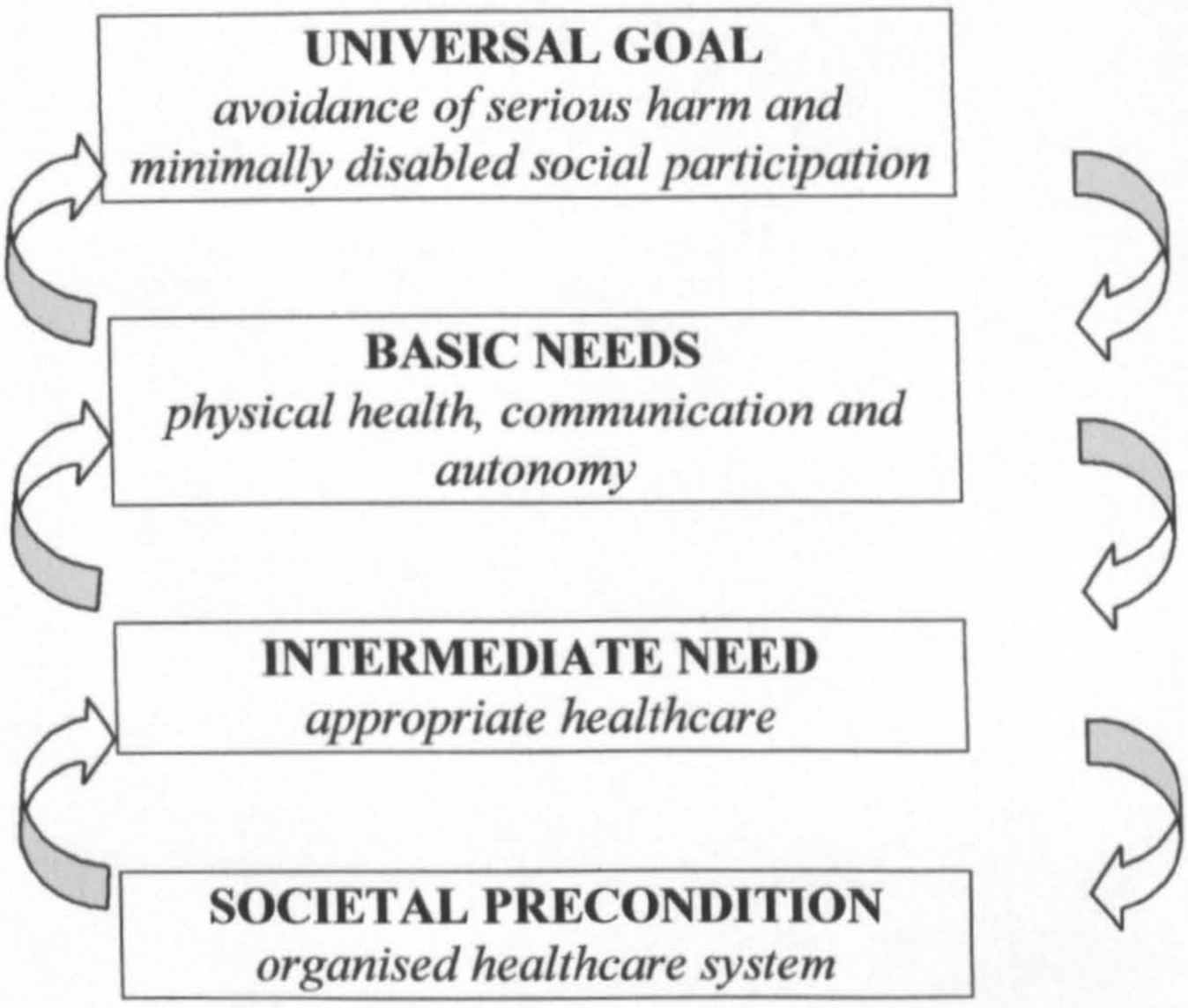

Figure 2.a (2)
(Adapted from Doyal and Gough 1991)

2.9 COMMUNICATION AS A HUMAN NEED

Communication has not been described as a basic human need in theories of need, including Doyal and Gough's. Communication is implied, as a requirement to meet other prescribed needs [Maslow 1943, Bradshaw 1972, Braybrooke 1987]. There can be little argument there. It is difficult to envisage how need satisfaction can take place without some form of communication. If we take examples from Doyal and Gough's list of intermediate needs then this notion can be explored further.

For example; a non-hazardous work environment can only be achieved in the light of effective communication. The machine operator in a factory needs to know, that is, to have communicated to her, the rules and guidelines for operating the machine safely.

She needs to know who to communicate with when errors occur and which mode of communication is appropriate. Information will be exchanged, interpreted and analysed to ensure actions are taken to maintain safety in the work environment. It may be that such information needs to be communicated to others. Differing roles and jobs in work environments need to be communicated and understood so that the smooth running of the work place is increased. Hours of work, absences, changes in practice and so forth are all dependent on communication.

This may lead us to accept communication as an intermediate need. But what if the work environment is thought of in terms of an intermediate need to meet the basic need of communication in much the same way as it is required to meet the needs of autonomy? Labour (and the focus is on paid labour) would need to be organised to ensure communication and information flows through systems and organisations. That is to say communication needs of individuals would need to be met within a work environment in order to avoid serious harm.

Significant primary relationships, along with appropriate education and appropriate healthcare indeed cry out for effective communication to facilitate positive need outcomes. It is impossible to imagine a significant primary relationship which is not dependent on communication. Whether the communication is good or bad communication per se will form the very underpinning of that relationship. When relationships breakdown it is often due to communication problems. Think of any family, couple, sets of friends and the maintenance of such relationships. Shared beliefs

and values, respect and affection are all known and understood through mutual verbal and non verbal communications behaviours. Relationships are forged with others fundamentally to meet the basic human need to interact and communicate. Any deprivation of the need to communicate causes harm in as much as individuals are restricted from participating in social interactions.

Given the argument so far using Doyal and Gough's ideas of societal pre-conditions, intermediate needs and basic needs where then should communication sit? Is it a societal pre-condition to meet intermediate needs which, are themselves the prescribed universal needs to maintain health and autonomy? Is it an additional intermediate need, or is it a basic human need? It is proposed in this thesis that communication is a basic human need and can be argued in these terms.

2.9.1 Communication as a basic human need

If health and autonomy are categorised as the basic human needs required for any individual to survive and flourish then communication as a basic need can also be argued on these grounds alone. Doyal and Gough state that:

> "...since physical survival and personal autonomy are the preconditions for any individual action, in any culture, they constitute the most basic human need – those which must be satisfied to some degree before actors can effectively participate in their form of life to achieve other valued goals."
>
> (Doyal and Gough 1991 p.54)

Doyal and Gough expand physical survival to the more fulfilling notion of physical health and explore the idea of personal autonomy to include 'higher' levels of autonomy, but fail to address communication substantially in their argument. Survival and autonomy are argued as universal teleologically stated needs. Human communication is also a universal constant and a precondition necessary to participate in any chosen form of life and remains so in any culture and society. In order to flourish in a chosen way of life individuals need to develop, formulate and achieve goals within their culture and, significantly, across cultures to communicate them. Such actions are in the best interests of individuals and societies in basic human terms. When human communication is endangered or impaired then one can argue that participation in a chosen way of life is also impaired. When impairment is severe participation is also dramatically impaired and can be defined as harmful on both individual and societal levels.

When part of individuals communicative abilities are impaired, for example, in cases of deafness, then individuals and communities go to great lengths to maximise the chances of deaf people to communicate effectively in order for them to participate in cultural and societal life. For the profoundly deaf British Sign Language (BSL) may be their first language. It is a language in it's own right and deaf communities generate their own culture within society. In the deaf world a deaf person is not disabled as her communication is not impaired by her deafness, but in the hearing world she is. The only thing that has changed is the communicative activity. In one world it is effective and in the other it is not and when it is not the individual is disadvantaged. The deaf

person may well need to operate in both cultures and by definition needs to communicate in both to ensure optimum participation and achievement. Educational attainment in deaf children is increased when teaching and learning methods meet their basic communication needs (Lynas et al 1997). Unemployment is proportionately higher in the deaf than hearing adults. (HMSO, DFEE 1999). This is in the main due to difficulties in communication between hearing and deaf people, not competence in relation to other aspects of the job.

2.9.2 Communication and serious harm

As individuals grow and develop it is clear that when communication is impaired the basic needs of health and autonomy as described by Doyal and Gough are endangered. That is to say that if individuals are unable to communicate health and illness needs adequately, they in turn, may not be able to communicate self-governing wishes unassisted. However, it does not follow that communication remains the intermediate need to meet basic needs of health and autonomy alone. Communication is fundamental, the very heart of what it is to be human and to flourish. Human beings have an inherent need to communicate. When people are unable to communicate effectively they suffer serious harm. This means they are disabled to such a degree that progress and achievements through social participation may be blocked. If the argument that ineffective, poor or impaired communication causes serious harm holds water, then communication can be defined as a basic human need in Doyal and Gough's terms.

It is impossible to think of any situation within society that does not require communicative activity in some form. Even a man alone on a desert island will have an internal dialogue and communicate with his environment using his senses. The need to communicate is as much to do with our humanity and our survival as is the need to procreate and avoid danger. The most devastating effect of solitary confinement and imprisonment is that the prisoner is robbed of communication need satisfaction.

2.9.3 The relationship between communication, health and autonomy

The need for communication remains with us throughout all stages of life, health and illness and in all or almost all, (brain stem death, for example, is an exception) types of disability or handicap. If a person is so disabled that they themselves find it difficult to communicate it does not take away their very need to do so. And this need is not to simply get other needs met, although this is no doubt an important function of communication, it is because our need to interact on some level, however we manage to do it, remains. Relatives and friends of very severely ill or disabled individuals can find that communication in these circumstances holds even more importance. Human contact, touch and voice may be the prime actions that provide comfort, peace or joy to both the ill and caring parties.

Human communication is basic need demonstrated at birth - a baby's first cry, the mothers first embrace. Communication is also a fundamental need in the process of dying. The common things people say matter the most when someone is dying are

generally concerns about being able to 'put their house in order', telling the important people in your life that you love them, communicating forgiveness, love, trust, fear, whatever. Sitting together, touching, mutual silence, demonstrating emotion, crying, laughing, sharing frustrations, disappointments and anger. *It is not just about feeling these things, it is about communicating them.* The sense that there is some sort of mutual recognition, acknowledgement and ideally understanding of thought and feeling is only achieved by communication. In a case of sudden death it is not uncommon to hear someone say 'I never got a chance to 'say how much I loved them', or 'say goodbye'. This can and does feel like an unmet need. Therefore need can be understood in negative terms because it is the 'lack of' which causes the distress.

When people are ill their autonomy may be threatened and this has been defined as causing serious harm, at least potentially. Likewise their need for effective communication may also be unmet *(as outlined in chapter one).*

2.9.4 Satisfaction of communication needs

We can consider communication need satisfaction using Doyal and Gough's logic. The foci of universality and objectivity remain.

- Universality of need

For the purpose of this thesis the discussion has veered towards universality and needs have been argued as such. This is especially so with human communication, as the need

to communicate is irrespective of any other conditions or influences. The way in which this is operationalised will be culturally specific. Cultural specificity will manifest itself in language, shared beliefs and values, shared meaning and interpretation of non verbal communication and a wide range of artistic expressionism and symbolic reproduction.

- Subjectivity and objectivity

The intimate process of interpersonal communication lends itself to the acceptance that this is likely to be a subjective shared experience. Subjectivity in this sense particularly relates to the sharing of meaning and understanding; the appreciation of another's perspective and the willingness to review ideas, beliefs and values in the light of communication. So it will be a combination of content and purpose that influences whether the communication is understood subjectively or objectively. However, it is important to universally protect individuals and societies adequate need satisfaction with regard to communication in objective terms. That is everyone everywhere has the right to communication need satisfaction.

- Adequate need satisfaction

Adequate need satisfaction may be defined as any communicative action which encourages and enhances an individual or societies ability to develop and flourish within their chosen way of life in much the same way as Doyal and Gough define need satisfaction of survival, physical health and personal autonomy. Conversely the lack of effective communication disables and reduces participation and achievement, and this is so for everyone every where. In addition, Doyal and Gough's list of societal pre-

conditions for adequate need satisfaction are as helpful for communication as other needs listed within their theory. This is because we are not considering communication in terms of 'any old communication', but effective communication which does not cause harm. The moral thread of rights and duties is helpful in the avoidance of harm by our communicative actions.

The discussion can return to Doyal and Gough's lists of intermediate needs to relate how and why these are relevant to meeting the basic need of communication in the same way they are to meeting the need for physical health or autonomy. It is not the purpose of this thesis to re-write Doyal and Gough's theory, but to argue that communication is a basic human need and can be considered as such using Doyal and Gough's approach. It becomes clear that some intermediate need satisfiers have more of an impact on human communication than others. Nontheless a theoretic relationship can be identified in specified conditions. An in depth exploration of intermediate needs is not proposed here as healthcare is the focus of the thesis. At this stage of theoretic development the aim is to raise the question that in principle communication sits alongside health and autonomy.

The 'why' of communication need satisfaction has been argued above in terms that are congruent with Doyal and Gough's theory of human need. But thus far in the argument an appropriate theory of communication has not been developed. However Doyal and Gough's' general need theory has drawn on communication theory, but only to support

their general claims. The next logical step to help with the progression of the thesis is to turn to a theory of communication.

The German political philosopher Jurgen Habermas discusses communication theory in objective universal terms, but also discusses the role of intersubjectivity in reaching the goals of shared meaning, understanding and truth. Habermas was influential in Doyal and Gough's own theoretical thinking in regard to communication in procedural terms. It would therefore, make sense to return to Habermas in some depth having introduced communication as a basic human need which sits alongside physical health and autonomy with equity. Habermas' theory of communicative action is turned to in the next chapter.

2.10 CONCLUSION

If communication is included as a basic human need then 'A theory of human need' becomes one of the most encompassing contemporary theories of need. Human communication, health and autonomy will be considered as the basic human needs that this thesis will refer to. Needs are addressed from the individual and collective perspective and the importance of cultural experience is recognised as well as the codified knowledge of professionals. The environment is seen to be important in influencing need satisfaction and this is set out in clear terms. Doyal and Gough provide a compelling argument for the universally applied definition of need, and the concept of need in objective terms is presented throughout.

The concept of cultural differences rather than relativity allows for differences in the processes and content of need satisfaction mechanisms. Human needs have been argued to be the same wherever we are and the intermediate need satisfiers are universal. This does not of course follow that all processes or outcomes are similar. These are culturally determined and culturally specific. The moral tone of the theory also dis-allows human deprivation to be considered purely as a relativistic theoretical stance.

In conclusion, therefore, the claim that universality and objectivity of human need is possible to demonstrate in abstract and concrete terms has significant support. This perspective can be argued more effectively than the relative perspective of subjective feeling alone and has been offered by others to add support to Doyal and Gough's approach. As a guiding rule it is commendable to attempt objective definitions of need as:

> "When the concept of need has a clear and determinate empirical content in comparison with other evaluative concepts, like those of beauty, freedom, equality and democracy, then agreement can be more easily reached about what needs people have and disputes concerning need can be settled empirically."
> (Thomson 1987 p.125)

With the safeguards of rights informing claims to need satisfaction, and communication processes aimed at meeting the goals of human communication, health and autonomy it can then be said that a route can be followed, which means that it is possible to begin to re-evaluate the notions of need satisfaction in healthcare.

At an abstract level Doyal and Gough set their theory in the contexts of charting human welfare, whilst recognising practical restraints. They conclude that such restraints do not negate the vision of the good which they outline throughout the theory. International comparisons are made and examples of substantive need satisfaction worldwide are given. (Worldwide issues are not concentrated on in this thesis to any great extent. Doyal and Gough have provided a wide and substantive theory, the breadth of which is not needed in its entirety for the purposes of this thesis). The purpose of this thesis is to describe the problems of communication in healthcare and how these can be better understood by regarding communication as a basic human need.

It remains to be seen if by the inclusion of communication as a basic need within this theoretic approach influences in any way the view held previously by others that Doyal and Gough are puritanical and somewhat authoritarian in their philosophy (Soper 1992).

What is beginning to emerge is a reflexive relationship between communication and health and autonomy. Communication can be argued as a basic need using Doyal and Gough's theoretic structure, but it seems too simplistic to accept a parallel relationship between the basic needs. Autonomy is required to communicate effectively and yet there is an identified need to communicate effectively to satisfy autonomy. These questions have been introduced in this chapter, not answered. Further theoretic argument will aim to address these questions in following chapters, with the provision of healthcare as the focus.

CHAPTER THREE

A THEORY OF COMMUNICATION AND ETHICS

3.1 HABERMAS: THE ROOTS OF A THEORY OF COMMUNICATIVE ACTION

Chapters one and two have brought the argument on to the stage of considering in more detail what sort of communication will help meet health and individual autonomy needs. To these ends it is helpful to turn to theory of rationality in the work of Jurgen Habermas. How Habermas' ideas offer a way of interpreting structural and procedural communication in the provision of healthcare will be described. This also provides a theoretic approach to deal with some of the problems outlined in chapter one.

Habermas (1981) argues a model of democratic reason through the institutionalisation of particular types of language and communication. He argues that social democratic communication constitute the means by which basic need satisfaction in the terms of Doyal and Gough (1991) can be optimised, although he does not adopt their specific discourse. To facilitate the achievement of what Habermas calls "generalisable interests"; he offers an ethic of human liberation built on consensus theory of communication, which is pragmatic, and goal oriented. The goal of procedures designed to achieve consensus is and should be that of mutual understanding between communicants in order to reach agreement. Habermas uses the word 'meaning' in its widest sense, more than linguistic understanding but interpretive understanding. This includes an appreciation of what any decision and subsequent action means to each

communicant, not in a narrow instrumental sense of strategic intent (consequentialist model), but in a sense whereby the communicant intends to express herself in a way which conforms to or criticises the structure of norms within her society (Habermas 1979). That is to say, what immediate and long term affects and effects decisions have on daily living and the pursuance of life goals and concordance (or not) with communicants' beliefs and values. Such values and goals may include wider ends within society over and above personal physical survival and may be driven by basic moral or religious norms. Such action is social in character and may even include risk taking or endangering self-preservation.

White calls this conception of practical reason in social science *strategic rationality* (White 1988 p.10-13) and aims to help us understand Habermas' communicative conceptions of reason and rationality:

> "Rational choice theorists see themselves engaged primarily in the task of building a naturalistic social science by beginning with simple assumptions about rationality and then predicting how individuals will behave in a given set of conditions."
>
> (Barry, *Economists* pp.1 – 6,165-172 cited in White 1988 p.11)

White argues that the conclusions of rational choice theorists are important since the logic adhered to demonstrates:

> "....What sort of co-operative collective action can be expected among individuals who share an attachment to strategic rationality, however divergent their other values might be."
>
> (White 1988 p.11)

Rational choice theorists focus on explanatory questions which raise issues about the degree of co-operation or conflict that can be accounted for, that doesn't appeal to motivations of purely self interest, but whether the benefits to the actor, of participating in co-operative action outweigh risks or threats. In the strict sense this approach does not endorse or recommend any particular moral position.

> "To be motivated in this way means to orient one's actions not only toward self but also toward creating or maintaining institutions and traditions in which is expressed some conception of the right behaviour and a good life with others."
> (White 1988 p.16)

This does not mean however that norms and traditions must be maintained at all costs. Habermas, unlike strict rational choice theorists does take the view that all communicants have a moral and democratic right to speech and to be heard (Habermas 1979). They also have a moral duty to listen to others. Within this paradigm all subjects who are capable of speech and action are afforded the following rights: each is allowed to question; each is allowed to introduce any proposal into discourse; and each is allowed to express individual attitudes wishes and needs. Thus, the following quote describes how Habermas' ideal of rational democratic communication might be the ideal communicative process required for effective communication in optimally successful healthcare:

> "The goal of coming to an understanding is to bring about agreement that terminates in the intersubjective mutuality of reciprocal understanding and shared knowledge, mutual trust, and accord with one another. Agreement based on recognition of corresponding validity claims of comprehensibility, truth, truthfulness, and rightness. We can see the word understanding is ambiguous. In its minimal meaning, it indicates that two subjects understand a linguistic expression in the same way; its maximal meaning is that between the two there exists an accord containing the rightness of an utterance in relation to a mutually

> recognised normative background. In addition, two participants in communication can come to an understanding about something in the world, and they can make their intentions understandable to one another."
>
> (Habermas 1979 p. 3)

As was discussed in the last chapter, if the provision of healthcare is to satisfy basic human need then it must respect autonomy, as well as preserve physical health. This means that the autonomy of patients must be respected through effective communication encouraging precisely the kind of 'accord' that Habermas has in mind. Over and above this, communication itself has been argued as a basic need and that everyone has the right to effective communicative practices on the same grounds. To the degree that this right is not respected, artificial limits will be placed on potential levels of need satisfaction conceptualised in the terms of Doyal and Gough (1991). For example, market structures demand democratic communication in order to function at optimal levels. The same can be said of health care provision and policy. For closure on democratic communication can lead to vital information being hidden to the detriment of public health.

Habermas offers a complex theory, the roots of which are in the philosophical and critical discourses on modernity and critical theory associated with the Frankfurt Institute for Social Research in the 1950's. Out of this 'school' came the term 'verrechtlichung'. This term describes the trend of legal regulation of private life. Habermas talks about a state of affairs which results in 'colonisation of the life world' (Habermas 1981 pp. 293, 417-488 in White 1988 ch. 5 pp. 90 – 123). What does this mean? Habermas is describing the expanding role of the state in society and families.

Outside influences such as growths in labour markets, social insurance and the welfare state become stronger than the family. The 'life world' of the family and communities become more and more encroached on by outside influences.

In the end, state, political and scientific systems impact negatively on the lifeworld by repressing traditional and symbolic reproduction which would naturally occur through social integration. This mediatization of the lifeworld assumes the form of colonisation (Habermas 1981 pp186 – 196).

The outside influences of the state will in turn influence public opinion through communication structures and processes. These in themselves are upheld or rejected by the politics of the day, the press and the media. This being the case, Habermas argues that these processes do not constitute democratic or rational communication, but are systematically distorted by those in power and with vested interests (Habermas 1981) (*see footnote 1).* What society is then presented with is a small number of activists influencing a large number of inactivists. The reading or viewing public may be uncritical and therefore public opinion ceases to be a source of critical judgment.

Footnote 1

Habermas was also influenced by psychoanalytical theory with regard to the relationship between systemic distortion of communication and colonisation of the lifeworld. For in depth analysis of the roots of Habermas' thinking and the influence psychoanalytical theory had on the development of his debate about systemically distorted communication see Russell Keat Politics of Social Theory: Habermas, Freud and the critique of Positivism, Oxford, Blackwell, London 1981; and Christopher Nash (Ed), Narrative in Culture, London, Routledge 1989

The mass electorate can be manipulated resulting in a possible dichotomy between what is seen to be public opinion, and the experience and views of the rest of society. Any general election in latter years in the UK provides a useful example of this argument. In the UK the average percentage of the voting public who choose to exercise their right is only around 60% (considered a good turn out). In other words, although most adult members of society have the democratic right to vote, a significant percentage choose not to do so. There must be a myriad of reasons why they do not participate. Perhaps they feel their views will not be represented or heard. If they do not understand, or indeed believe in the political argument, they may think: *Why bother?* Or, *I do not want to support the choices on principle*. The latter response suggests that the individual has reached a level of understanding to make a critically autonomous decision given the information presented. Whereas the former suggests that although purporting to be a democratic process the communication processes perpetuate the power of authority.

The situation as described above requires critical thought on several counts. Given the argument as presented in the previous chapter, we could say that those in society who are not provided with the means to participate in democratic processes in a meaningful way have the potential for reaching the level of critical autonomy reduced. This is so even when taking into account degrees of educational and intellectual attainment. The right to effective communication, which encourages mutual understanding, is the rational way for society to operate. Without such understanding, the political processes underpinning any society may be described as irrational. It might also be argued that

low voter turn out is a reflection of a wider malaise in society and that those who do vote do not, by definition, *agree* with the current form of democratic voting models.

> "The contradiction is obvious: a proliferation of the social conditions of private existence that are maintained and secured by public authority, and therefore ought to be clarified within communication processes of a politically autonomous public of citizens, that is, should be made a topic for public opinion. Although objectively greater demands are placed on this authority, it operates less as a public opinion giving a rational foundation to the exercise of political and social authority, the more it is generated for the purpose of an abstract vote that amounts to no more than an act of acclamation within a public sphere temporarily manufactured for show or manipulation.....
>
> .... Public opinion takes on a different meaning depending on whether it is brought into play as a critical authority in connection with the normative mandate that the exercise of political and social power be subject to publicity or as the object to be molded in connection with a staged display of, and manipulative propagation of, publicity in the service of persons and institutions, consumer goods and programmes."
>
> (Habermas 1962 pp. 222 & 236)

This is not to say that all things being equal individuals do not have the negative right to non-participation. The rational view is that they have, but non-participation and negative freedom ought to be in the light of effective communication and understanding which implies mutuality and consensus. They could participate should they so wish, but choose not to do so. Were Habermas' model of reason achieved, it would be through the democratic right and access to structures and processes.

Habermas' early concerns with the nature of modern democracy, power and dogma, the scientization of politics and other spheres of life, and methodologies for social sciences led him onto the work which underpins this vision of a participative and optimally rational society - A Theory of Communicative Action:

> "In the second half of the nineteenth century, during the course of the reduction of science to a productive force in industrial society, positivism, historicism and pragmatism, each in turn isolate one part of this all encompassing concept of rationality. The hitherto undisputed attempt of the great theories, to reflect the complex of life as a whole henceforth itself discredited as dogmatic. Reason, once it is particularized, is assigned to the level of subjective consciousness, whether as the capacity for the empirical verification of hypotheses, for historical understanding, or for the pragmatic control of behaviour. At the same time, interest and inclination are banished from the court of knowledge as subjective factors. The spontaneity of hope, the act of taking a position, the experience of relevance or indifference, and above all, the response of suffering and oppression, the desire for adult autonomy, the will to emancipation, and the happiness of discovering one's identity - all are dismissed for all time from the obliging interest of reason. A disinfected reason is purged of all moments of enlightened volition; external to itself, it has externalised - alienated - its own life. And life deprived of spirit leads an existence of arbitrariness that is a ghostly spirit indeed - all under the name of decision."
>
> (Habermas 1974 p.262)

Habermas argues that actors need to be able to relate and reflect communicatively on three worldviews - not just a scientific or political one - in order to achieve effective rational communication. The three worldviews as he defines them are: objective, subjective and social; and operate within three cultural spheres: science and technology, law and morality and aesthetics (Habermas 1981 vol. 1, p.238). Habermas' three worldviews requires an ability to differentiate and select the most appropriate interpretation for any given situation and work out common agreement. Habermas offers a theory within which a democratised concept of reason makes transparent the human values and generalisable interests that drive societal processes (Habermas 1976). This critical theory was his response to the largely pathological effect that modernist capitalist society and the pseudo freedoms that welfare states offered society. Habermas offers a reconstructed communicative infrastructure which aims to re- balance the

'culturally impoverished' practice of everyday life that has been the result of political power, scientization and dogma.

> "....a reification of communicatively structured domains of action that will not respond to the media of money or power. The issue is not one of primarily compensations that the welfare state can provide, but of defending and restoring endangered ways of life. In short, the new conflicts are not ignited by distribution problems but by questions having to do with the grammar of forms of life."
>
> (Habermas 1981 p.392)

For this reason the organisation and delivery of healthcare would seem a suitable subject for Habermasian analysis. Habermas offers a general theory, which pertains to society as a whole. However, the key principles apply to healthcare in much the same way. A model of optimally rational communication within society can be translated into a model for optimally rational clinical communication. To what extent Habermas' vision of collective reason can be applied to the structures and processes of healthcare provision, suggesting how the basic needs of patients can be optimally satisfied will be explored throughout this thesis.

3.2 A THEORY OF COMMUNICATIVE ACTION

There are four concepts in what Habermas calls his theory of communicative action: the power and the systematic distortion of communication; the colonisation of the lifeworld; and the relationship between truth and consensus. Finally, Habermas offers what he calls an ideal speech situation as the ultimate goal that democratic communicational structures and processes ought to aim for (Habermas 1981).

Habermas describes communicative action as a form of linguistic interaction where all the communicants perform action in speech with the aim of achieving consensus and understanding. This, Habermas suggests, is the original social mode of language use. Habermas thinks about communication teleologically. That is to say, the pre-determined purpose of human communication is to reach understanding and consensus and this is a natural and universal phenomenon. This purpose is transcendental in Kantian terms – it is presupposed by the intelligibility of all specific speech acts, irrespective of their particular type or goal. Any instrumental use of language is thus supplementary, or in Habermas' terms, parasitic to the original pure intention for language. His view is:

> "....The use of language with an orientation to reaching an understanding is the *original mode* of language use, upon which indirect understanding, giving something to understand or letting something be understood, and the instrumental use of language in general are parasitic."
>
> (Habermas 1981 pp. 288 92)

Instrumental action in this context relates to productive activity and material interchanges within environments, much in the way that Marx argued *(see footnote 2)*. However, instrumental action is open to abuse in the sense that domination by vested interests, or the needs of power bases are allowed to take precedence over communications original use (Outhwaite 1994 p.16 - 19). For Habermas, communicative action focused on consensus building has priority over instrumental

Footnote 2

For a comprehensive discussion see Rasmussen D.M. (1979) Marx: On Labor, Praxis and Instrumental Reason. Dialectics and Humanism, 3, pp.37-52.

action in that it explicitly suggests the moral values that the latter must also presuppose in order to be optimally rational. For example, dictatorships notoriously flounder because of the suppression of unwanted criticism and therefore the undermining of feedback loops necessary for sustained instrumental success. In this way Habermas distinguishes between a communicative action which is not linked to strategic or instrumental change, and instrumental or strategically motivated communication. When communicative action is of this kind it can provoke agreement or disagreement based purely and simply on reason rather than its potential or actual instrumental success. (Habermas 1981 pp. 287-292). Strategic communicative action, however, is open to distortion and influence driven by the vested interests of authority and politics (Habermas 1981)

3.2.1 Systematic distortion of communication

Communication, which is distorted by powerful groups or those with vested interests, is a problem because such communication may result in a false ideology. This may take the form of conscious deception through the use of language geared to strategic action made possible through political power. Habermas goes on to describe strategic action in this sense as 'structural violence' by way of systematically restricting communications (Habermas 1981 vol. 2 p.187). The process of systemic distortion of communication has the effect of cutting short or excluding individuals. This occurs either through the process of elitism and specialised knowledge transfer or the 'splitting off' of different cultural spheres. This results in increasingly specialised forms of

argument that are not necessarily predicated in rationality or reason but can be predicated in strategy aimed at meeting their own vested interests.

It has been pointed out *(chapter 1 p.20)* that the National Health Service has developed in relation to vested interests and power bases rather than solely to satisfy basic human needs. This has been reflected in the long history of inequality of power in the doctor/patient relationship. Habermasian analysis would conclude that this has been achieved through the power of carefully and strategically operated communication (Habermas 1981 vol. 1 pp. 332- 334). It would possibly be harsh to accuse policy makers and clinicians of conscious deception, or having less than noble intentions. It would be a mistake to make yet another distortion of interpreting power as good or bad. Habermas uses the term power to mean unjustified domination.

Foucault who considers power as productive offers a worthwhile and alternative perception – as the veritable engine that drives social and historical process (Foucault 1970, 1975, 1991). Institutions such as medicine, religion and law according to Foucault are coercive institutions in as much as they discipline individuals and monitor or survey everyday life and practices. By doing so they both produce and constrain human actions. Foucault emphasised that power was everywhere and that where there was power there was always resistance (1980). In his later writings he began to pay more attention to the phenomenology of self-discipline and power relations (1988). Lupton interprets Foucault's shift of emphasis as significant in that Foucault began to be more interested in how individuals act upon themselves and their interactions with

others. The phenomenology of power rather than the technology of power meant that Foucault was able to expand his theoretic thinking from the notion of power operating on individuals through institutions, to how individuals managed 'self' in every day life.

> "Central to this new emphasis on self-discipline is a focus on the interrelationship between the imperatives on bodily management expressed at an institutional level and ways that individuals engage in the conduct of every day life, and the ways that resistance may be generated at those levels by people refusing to engage in those techniques and strategies."
>
> (Lupton 1997 ch. 5 pp. 101 –106)

Unlike Habermas who defines power as a violent and dominating force, Foucault argues that the exercise of power is both legitimate and inevitable at all levels of social interaction and within all aspects of social structure and process.

It is the potential for power to sustain social structures, as well as to challenge them in the face of new practical demands, that makes it a productive rather than destructive force. Seen in this context, the exercise of power is essential in the exercise of all forms of creativity that become materially or technically embodied. It can, of course, also induce pleasure. Power doesn't only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse. The constraints always present in relationships of power are argued by Foucault to make social change possible. For without the boundaries of discourse that such relationships control, creativity would be dispersed and without structure. Whatever challenges the new poses, the old would not be able to retain its focus. Thus, power should be considered as a productive network, which runs through the whole

social body, much more than as a negative instance whose function is repression. (Foucault 1984a: 61)

By being involved in everyday problems of individuals the coercive character and indeed intentions of medicine can be disguised. People seek out, and to some degree, accept any authority that medicine has over them in the quest to have their problems solved. Foucault's view is that if intermingled with knowledge, power does not have to result in or resort to a false consciousness. A Foucauldian perspective is that power is not the possession of particular groups but that power is a relational strategy and transmitted between groups. This does not mean that there is not resistance to power. In fact the resistance of one set of power tends to result in another new set of counterpower, (Foucault 1980, 1982).

Habermas would accept some aspects of Foucault's insights; for example, the needs of coherent discourse to have defining boundaries of semantic structure and accepted use (Habermas 1976). However, he rejects the idea that such structures are all morally equivalent – that it is impossible to make historical and political judgments about whether or not the exercise of power either does or does not morally further human emancipation. When discourse is inconsistent with such goals, its use can be questioned. For example, discourse may be distorted through the imposition of vested interests incompatible with the collective achievement of optimally rational communication. Such distortion can be intentional but it can also occur without the conscious intention of those involved, and it is this form of distortion that Habermas is

talking about (Habermas 1981 vol. 1 pp.333-34). For example, take a health professional that operates from the position of a beneficent patroniser. She may well have the patient's best interests at heart but despite her good intentions, this is not the outcome. Thus, until recently it was common practice to withhold information about terminal illness from patients in the erroneous view that it was better for them not to know. This meant that patients were robbed of the opportunity to participate in arrangements for their care and death, to be with and talk to who they wished, to complete wills and so on. In other words they were not able to 'put their house in order' with any degree of intentional planning or a full understanding of what effect their illness or impending death would have on them and those close to them. This is not to say that all patients want to know everything, but that properly trained health professionals have the skills to explore and share information with patients and relatives about their diagnosis, treatment and prognosis, at the level of detail they require; and that they should use them.

The first approach (e.g. crude paternalism) is an example of 'purposive-rational' action in Habermasian terms and an example of distorted communicative action. It is about medicine's role in usurping the control that humans normally express over their lives and dominating communications through medical knowledge. This in turn results in a failure to value and acknowledge the patient's valid claims and experience. The second approach (that of negotiation and consensus) requires linguistic interactions aimed at achieving understanding through negotiation and consensus and for this reason constitutes 'communicative' action. Thus communicative action can be understood as a

separation of speech act sequences that are internally organised and accord to the principle of understandability, truth, rightness and sincerity; and externally, and context based acts which refer to time, place, who can participate and when. Problems occur when external organisation overloads discourse, thus displacing internal organisation and systemically distorting communication. (Habermas 1984 in Outhwaite 1994 ch.3 p.43). It is this mode of action (communicative action) that should characterise the attempts of clinicians to develop relationships of partnership with patients in arriving at treatment decisions.

Other examples of systematic distortion in healthcare may be found in research and treatment. Take the Thalidomide tragedy in the 1960's, an extreme example. Developmental research data indicated the toxic effects of the drug Thalidomide on a developing foetus. However, this information was distorted and findings were published indicating that the drug was safe (Stephens and Brynner 2001). The instrumental goal in doing so was profit. The drug was introduced in Europe and licensed as safe in early pregnancy. To this end the drug was widely prescribed resulting in the births of 'Thalidomide babies'. Commonly, babies affected by the drug were born with undeveloped limbs. Later on when more accurate undistorted information became available there followed numerous successful claims against the Drug Company for compensation on behalf of the growing children. They succeeded partly because it was accepted that the strategic action of the drug companies was not concealed, but overt.

More recently has been the Bristol case in the UK (1999) that is centred around distorted communication on several levels and power bases. Parents with small babies with congenital heart disease were encouraged to give consent for their babies to undergo major heart surgery. The fact that the surgery was essentially experimental and part of a research trial was not communicated to the parents. Their right to communicative action (interaction aimed at achieving understanding) undistorted by the dominant power of the medical profession was denied. The subsequent death rates were identified in audit procedures and deemed to be unacceptably high. Ultimately the cases went to the high court accompanied by huge national media coverage. Both the medical and legal professions listened to, parents in the Bristol case eventually. Strategic action was overtaken by communicative action in this process. Context based external organisation dominated internal organisation of speech acts and prevented communicative action taking place. Indeed, the conduct of the Bristol Inquiry (2001) itself embodies the goal of what Habermas argues can be undistorted communication and attempted to redress this balance.

Individual health professionals were uneasy about the practice in Bristol, but did not divulge their concerns at the time. 'Whistle blowers' in the NHS tend to receive a mixed response – usually negative, from their fellow health professionals. The practice of covering up or colluding in mistakes or unacceptable practices has been acknowledged as a problem in medicine (Sexton et al 2000, Mizrahi 1984). These problems were brought to public attention in a case like Bristol. The General Medical Council (1998) responded to government recommendations and produced guidelines for future practice

focusing on the role of clinical communication in consent procedures and clinical governance. The parents involved in the Bristol case may not feel that they were a new counterpower as described by Foucault. However, there is no doubt that they did become more powerful and the balance of discourse was changed through the legal process.

Unfortunately, there remains a direct link between the medical environment and the opportunity for institutionalised distortion of communication. This consists of the vested interests in the provision of services, the balance of power and status between health professional and patient, and the codified knowledge and medical jargon used by health professionals in their everyday communication with themselves and patients. These processes not only distort communication but, as Habermas puts it, colonise the everyday lifeworld.

3.2.2 Colonisation of the lifeworld

Habermas distinguishes between systems and the lifeworld. That is to say scientific systems, technological systems and political systems and the everyday lifeworld. When systems imperatives superimpose themselves over lifeworld imperatives then a distortion of the lifeworld occurs (Habermas 1991 pp. 145 – 56). In other words, colonisation of the lifeworld is another form of systematic distortion achieved by power and influence. The traditional values and norms of cultural groups and society are usurped by the values and norms of 'experts', or those with codified knowledge. It is

those with codified knowledge who are likely to be in positions of power and influence and can therefore, by the use of strategic communicative action, influence traditional views.

> "The expansion of systems integration begins to undermine functions essential to the rationalised lifeworld. The mediatization of the lifeworld takes on the form of 'colonization of the lifeworld when the systemic media of money and power begin to displace communicative sociation in core spheres of action within which the three processes of symbolic reproduction take place: cultural transmission, social integration and socialization."
>
> (Habermas 1981 pp. 145 – 56)

In practice, active citizens are turned into clients (or patients in healthcare) who do not have equal participation in public debate. Debates may be presented to the public via the media, but the socially integrative processes that characterise rational debate are denied and ultimately lead to 'cultural impoverishment'. Such reduction of communicative action in any public sphere disallows the creation, sharing or passing on of lifeworld values.

The problem in Habermas' view is that the modern subsystem of economy and state reproduce themselves materially and interfere in the process of the symbolic reproduction of daily life (Rasmussen 1990 p. 47). Whereas "social integration" in the lifeworld involves consensual coordination and is communicatively structured, Habermas argues that this is not so in "system integration". System integration is described as a structurally violent process, which restricts and distorts communication and acts 'over' intersubjective forms of understanding. In the end, therefore, systemic

mechanisms suppress forms of social integration, the lifeworld is threatened and this mediatisation of the lifeworld assumes the form of a colonisation:

> "Neither the secularization of world views nor the structural differentiation of society has unavoidable pathological side effects per se. It is not the differentiation and independent development of cultural value spheres that lead to cultural impoverishment of everyday communicative practice, but an elitist splitting off of expert cultures from contexts of communicative action in daily life. It is not the uncoupling of media steered subsystems and of their organised forms from the lifeworld that leads to the one sided rationalisation or reification of everyday communicative practice, but only the penetration of forms of economic and administrative rationality into areas of action that resist being converted over to the media of money and power because they are specialised in cultural transmission, social integration, and child rearing, and remain dependent on mutual understanding as a mechanism for coordinating action."
>
> (Habermas 1974 p. 330)

Hence Habermas derives a pathology from his distinction between system and lifeworld.

This analysis of the colonisation of the life world is not unproblematic. The most basic criticisms are, firstly, the difficulty in maintaining the duality of system and lifeworld. The social complexity of modern society makes any sharp division between what is natural or normal and what is artificial somewhat arbitrary. Indeed Habermas himself is not entirely clear about what makes up or defines the life world. Modern family and societal life means that input is actively sought from the systems world as well as being coerced into accepting input. Professional advice is sought from educationalists, lawyers, doctors and so forth in order to enhance, maintain or protect family life and what is more do not, it is believe such input can be a good thing. Equally, sometimes a degree of colonisation is required for both the possibility and sustenance of a range of

strategic actions, especially those related to various forms of science and technology. Thus, it is unclear what it would mean to try to integrate the life world into neurosurgery, for example, or why this should be thought even worth considering.

In addition, the reader is left to come to her own conclusions about the role and influence of culture. Is cultural influence part of the life world or systems world, or both? Habermas states universal and generalisable claims about the purpose of communication both collectively and individually, but does not give us any ideas about how influential culture is on the achievement of optimally democratic communication processes at collective or individual levels. Habermas leaves this open to debate. However, it could be argued that cultural influence plays a part in both systems and life world however this is defined.

Perhaps the lifeworld should be interpreted as the following: *The lifeworld is made up of our family (however that is culturally defined), friends, colleagues and contacts that are maintained through social contact.* Such social contact will include interactions with the systems world. However, in so doing the primary intention is not to meet the needs of the systems world but to maintain and enhance a healthy lifeworld. If successful, such interaction will be perfomed using Habermasian rules that engender better friendships, better relations with colleagues and more rational social interaction. It is in this way that the life world persists and evolves.

As Habermas himself is not entirely clear about what or who make up the lifeworld or about how power is operationalised in it, we could be led to believe that power and influence is not a problem in this sphere. However, caution is needed in accepting the inherent assumption that irrational manifestations of power and influence are absent from the lifeworld. Honneth (1985) has argued this point. This is known not to be so - look at any family. Secondly, the communicative thesis is grounded in a utopian assumption about the way society ought to be, (Rassmussen 1990 p. 55). Despite these criticisms, the idea of colonisation of the lifeworld, and the problems that occur as a result of this process with regard to autonomy and communication needs, can certainly be identified in healthcare.

Using a Habermasian analysis one finds there are many examples of medicalisation of the lifeworld, a form of colonisation. The experience of pregnancy and childbirth is a powerful example. Pregnant women become patients even though they may be fit and well throughout their pregnancy. Pregnancy, labour and childbirth are managed as a medical condition. The locus of control has been taken away from women, even to the extent of choosing the physical position in which to deliver their babies. The social and feminist perspectives of women and childbirth are well documented (Oakley 1984, 1987 and Kitzinger 1962, 1978). It may be useful at this point to differentiate between medicalisation and medical imperialism and that there may be concern about one or both in any given argument. Medicalisation refers to the model of biomedicine dominating all other models; beliefs and values about any given issue in health and illness. Medical imperialism refers to wider vested interests, power and control.

It is the communication issues that are the concern of this thesis. The encroachment of medicine into childbirth has resulted in the upsurge of new social movements and women's groups that have challenged the medical establishment and the 'rightness' of medical control and modern obstetric practice. The corporate sponsorship role in the 'creation' of disease is not new, but continues.

One of the most recent examples of what is often referred to as "medicalisation" is female sexuality operationalised primarily with reference to definition in the form of sexual function (Moynihan 2003). Moynihan describes the re-categorisation of sexual difficulties, to dysfunctions, to disease and questions the motivation behind recent research. Is this newly defined disorder identified to meet unmet needs or to meet the vested corporate interests of the pharmaceutical industry? Although it could be argued that the potential benefits of medicalisation of female sexuality may encourage further research and awareness into the complexity of female sexual problems the accompanying danger is that alternative views may be dismissed in the favour of a pharmaceutical definition and urge to prescribe.

Some have argued that new social movements such as this may not be politically motivated or concerned with counter power. Robinson and Henry (1977) state that self help groups are not a political phenomenon but *people who are coming together to share and solve their common problems, rather than put up with the frustrations and humiliations of professional services*. But the coming together of groups and narrative sharing does provide a range of functions. Stewart (1990) argues that these are an

increased confidence and competence and a willingness to question professionals beliefs. Kelleher (1994) supports this view and says that self help groups enable members to feel more confident about their own knowledge and beliefs and to challenge medical knowledge. This engagement in communicative interaction is not simply about the group challenging medical knowledge per se or even reaching agreement. It is an engagement of integrative processing that reaffirms their own identities and membership of their lifeworld. Habermas views lifeworld talk as being primarily concerned with the construction of meaning as opposed to instrumentally rational kinds of interactions which are primarily concerned with outcomes only. The most common patient/doctor interaction is instrumentally rational. That is to say the doctor has her agenda and 'distorts' the consultation to meet this end. Patients' own everyday experiences are seen to be irrelevant in the doctor's pursuit of her own concerns. This point had been extensively developed and argued by Mischler (1984).

There are clear examples of social groups politically challenging and resisting professional control that are political however, most notably in the domain of mental health. Politically oriented campaigning user groups challenged an amendment to the 1983 Mental Health Act in 1988. Their objections were about proposed treatments on a compulsory basis. Objections particularly focused on debate about the definition of mental illness, unreliability of accurate diagnosis and the infringement of mental health rights through involuntary admission and detention in hospital.

Shapiro (1983) explores scientisation in this field in more depth and suggests that one ought not to underestimate the power and influence of medicine even in the light of change, as the medical establishment has a great capacity to absorb change and retain power. And Habermas himself proposes that both systems and lifeworlds form complex societies (Habermas 1987: 118). Medicine is an enormously powerful system which has taken many human conditions out of the public sphere into it's own rarified and codified system which makes challenges from those outside it difficult. The result may be that the only understanding that people have of their health problems is a medical one and this will influence the way they perceive themselves and how they live their lives (Kelleher 2001). This is precisely Habermas' argument – system values over ride lifeworld values such as socialisation and integration.

> "If the only understanding that people have of their condition is the medical one then this comes to dominate the way they live, or feel they should live, and their lives are constrained by what are experienced as rigid treatment routines, to the exclusion of social relationships and even work."
>
> (Kelleher 2001)

An international example of colonisation of the lifeworld by strategic communicative action in order to meet corporate vested interests, with tragic results, was the Nestle campaign in Asia. The multinational corporation, Nestle, promoted powdered baby milk in India via a widespread advertising campaign. The message was that formula was better for baby, and pictures of chubby white infants accompanied this. In order to keep up with perceived progress in the western world, Asian mothers took to abandoning breast-feeding in favour of using formula. Along with this abandonment infants lost the immunological protection afforded them by breast milk. Infants were at risk of

diarrheoal disease and potential death. This was because the mothers did not have access to clean water supplies, sterilising equipment and other basic resources to ensure safety in the feed. By responding to the message encouraging them to attain the status of well-heeled western mothers free of the tie of breast-feeding they were unknowingly putting their babies in positions of potential harm. Ironically in the West, health professionals were encouraging mothers to return to the practice of breast-feeding for the accompanying health benefits offered to babies.

Habermas offers a model of what he calls an 'ideal speech situation' where he attempts to neutralise the negative effects of domination and power and can aid emancipation through enlightenment.

3.2.3 Ideal speech situation

Habermas relies on truth being achieved through consensus and when consensus is reached through democratic speech rights, this results in an ideal speech situation. It is morally right and rational for societies to aim for ideal speech situations for all actors within the society. Habermas offers rules, by which ideal speech and claims of truth telling can be achieved, these are:

1) Each subject who is capable of speech and action is allowed to participate in discourses.

2) Each is allowed to call into question any proposal; each is allowed to introduce any proposal into the discourse; each is allowed to express her attitudes, wishes and needs.

3) No speaker ought to be hindered by compulsion - whether arising from inside or outside of it - from making use of the rights secure under one and two.

Habermas argues that by conforming to these rules 'rational reconstruction' can occur. He claims that these rules provide a universal core of communicative competence needed to reach understanding. When we speak we are actually doing something and Habermas attempts to string together the varied things that people do in uttering sentences into a system of validity claims:

> "When a speaker orients himself toward understanding - that is, engages in communicative action- his speech acts must raise, and he must be accountable for, three rationality or 'validity claims' (Geltungsanspruche): truth, normative legitimacy and truthfulness/authenticity. Only if a speaker is able to convince his hearers that his claims are rational and thus worthy of recognition can there develop a 'rationally motivated agreement' (Einverstandnis) or consensus on how to coordinate future actions."
>
> (Habermas 1981 pp. 69-70)

Habermas therefore, claims that utterances can be assessed as rational or irrational in light of criticisable validity claims and objective judgment. Individuals develop the know-how required to do it consciously and unconsciously. Using the Habermas model, development of communicative competence depends on the interrelated competencies of cognition, speech and action. If actors achieve a level of communicative competence then they will have the capacity to generate the kind of understanding necessary to

master and sustain on going interactions which are understanding oriented. This point is particularly relevant to communication in healthcare. It is important to be clear about whose competencies are under discussion. The health professional may be competent in using medical jargon which is fine, but in order to generate understanding in her patients she will also need to 'translate' this codified language to everyday language. Habermas shares some similarity the works of others such as Chomsky and Piaget (White 1988 p.29) in as much as communicative competencies are shared. Chomsky offers a theory of linguistic competence and Piaget offers a theory of the development of cognitive competence. However, it is not these two competencies themselves which provide an ideal speech situation but the ability to demonstrate competencies in an interaction *(see footnote 3)*.

This is an interesting dilemma for health professionals' education and practice. How far can the notion of communication competence be pursued in clinical interactions? How equipped are health professionals, especially doctors, to interpret or make judgments about patient's competence and understanding? Moreover, should they adapt their communications accordingly? Habermas does not tell us *how* to do this but that it is rational to try.

Footnote 3

1) 'Cognitive competence': mastery of the rules of formal, logical operations (Piaget).
2) 'Speech competence' (sprachkompetenz): mastery of the linguistic rules for producing situations of possible understanding.

a) mastery of the rules for producing grammatically well formed sentences (Chomsky's 'linguistic competence').

b) Mastery of the rules for producing well-formed utterances (universal or formal pragmatic rules)
3) 'Interactive competence' or 'role competence': mastery of the rules for taking part in increasingly complex forms of interaction.
(White 1988 p 29)

Not only does Habermas say that it is rational to pursue democratic ideal speech situations and develop interactive competence, but there is also a moral imperative to do so. This position supports the argument put forward in the last chapter regarding meeting human communication needs. Interactive competence implies reciprocity; that is to say, "if I say something to you then you 'ought' to reflect on what I say". The moral viewpoint in Habermasian terms is to demonstrate conscious reciprocity that arises naturally in maturing individuals. He calls this *'the naturalistic kernel of moral consciousness'* (Habermas 1983 p 182). Others have made similar claims such as Kohlberg, who offers six stages of moral judgment (Kohlberg 1971, 1973). Stage six of Kohlberg, the universal ethical-principle orientation encapsulates in abstract terms this position:

> "Right is defined by the decision of conscience in accord with self-chosen ethical principles appealing to logical comprehensiveness, universality and consistency. These principles are abstract and ethical (the golden rule, the categorical imperative); they are not concrete moral rules like the Ten Commandments. At heart, these are universal principles of justice, of the reciprocity and equality of human rights, and of respect for the dignity of human beings as individual persons."
>
> (Kohlberg, 1971)

The moral imperative of the principles outlined by Habermas and Kohlberg are important in the analysis if the role of communication in healthcare because the application of these principles reduces the impact and influence of vested interests and encourage personal autonomy in patients. Communication in medicine, like medicine itself, should aim to do no harm. The link between reduction of autonomy, opportunities for effective communication and potential for serious harm have been outlined in the previous chapter *(pages 85-103)*. In addition, Habermas argues the superiority of

attempts to reach understanding which result in enlightenment above dogmatic or power-orientated communication.

3.2.4 Enlightenment is superior to dogmatism

The centrality of understanding in Habermas' argument is vital if consensus is to be reached. Understanding depends on the inter-subjective recognition of validity claims that are rational, in as much as the observer and the agent accept such claims as valid. Understanding and consensus that has been reached through communicative competence allows for reflection. These processes in turn allow collective and individual liberation and emancipation. Habermas considers these positions as steps towards autonomy. Knowledge and communicative action as understood in Habermasian terms are not used to reify or manipulate, but to enhance individual autonomy; '*...But which instead advance the interest of reason in human adulthood, in the autonomy of action and in the liberation from dogmatism.'* (Habermas 1974 p 256). This is not entirely without difficulty as he goes on to speak of the unavoidable vindicating superiority of those who do the enlightening over those who are to be enlightened. This point highlights the potential conflict in Habermas' argument. In order to be enlightened there is a requirement to seek knowledge. If therefore, such knowledge is gained from the 'experts' who offer knowledge in a codified censored or distorted form, then enlightenment, in the sense that Habermas means, is not the outcome. The outcome is a perpetuation of the negative effects of domination and power and not neutralisation of power, which is Habermas' preferred outcome.

Habermas has attempted to deal with this dilemma in later works and develops the idea of discursive democracy (Habermas 1999). These ideas have also shifted the focus of discussion from the dualistic model of either/ or systems and lifeworld to mediative processes.

3.2.5 Discursive democracy

Here Habermas is concerned with a different sort of democracy to the traditional liberal constitutional majority and civic communities, to pluralisitic multicultural and by definition, diverse modern societies. Habermas' argument is that in modern radical democratic politics changes in law and institutions can be influenced through discursive practices. This will require universal procedures, not necessarily universal values (Habermas 1999). He argues that it is through democratic communicative action that lifeworld problems can be brought into the public sphere and that solutions can be operationalised through institutional processes. However, in order for this to take place democratic institutions need to adopt liminal qualities. Jones (2001) interprets this to mean the following:

> "In this respect liminality can be interpreted as the capacity of institutional frameworks to change without being destroyed."
>
> (Jones p.169 2001).

This view, on the face of it, conflicts with Doyal and Gough's model whereby objective universal values hold true and are operationalised in culturally different ways. It is unclear what Habermas means by postulating a plurality of values in this sense. He

clearly does not do so throughout his analysis of communicative action and its central moral assumptions and through his endorsement of universal human liberation through the fulfillment of universal human interests. What he may be arguing is that how such interests are instantiated in practice should not be dictated by political or professional domination but by rational deliberation, which might lead to culturally different solutions. If so, this approach is consistent with Doyal and Gough's analysis of the cultural relativity of the choice of satisfiers for intermediate need satisfaction. In any case, using Habermas' idea of discursive democracy, society in the UK has reached a consensus that provision of healthcare ought to be available to all as a matter of moral right. Public opinion may not agree about the *what* and *how* of such provision, and indeed Habermas does not help us with this component of the argument. He does not address cultural diversity at this level. Habermas' lack of emphasis on culture continues to attract criticism (Jones 2001). But procedurally, in order to meet the demands of discursive democracy, lifeworld problems and solutions need to be brought into the public forum where argument can take place between experts and others. This linking of lifeworld and system world allows integration into institutional frameworks and can be implemented through law and institutional processes.

Public opinion has been afforded some place at least in the provision of healthcare. The examples previously described in women's services and mental health *(pages 155 and 157)* are examples of public opinion which forced a debate with experts resulting in public views being taken into account. Recent moves to increase the patient voice in

healthcare have been integrated (to some degree) with the ironically titled roles of patient educators or patient experts (DOH 2000).

As Habermas does not take into account cultural diversity to any great degree we are left to take the view that communicative procedures as described so far will also deal with any cultural conflict within lifeworlds as well as taking on or being given space by the system world.

The tenaciousness with which medicine holds on to power through codified knowledge despite some moves that Habermas may approve of cannot be underestimated. However, despite these difficulties, it follows from Habermas' arguments that introducing and responding to public debate through communicative action, is the rational way forward for healthcare and society. Decision making in healthcare can never be value free (Jones 2001). There would be little point in arguing otherwise. Political debate will no doubt continue. This is not to say however, that effective communication practices ought not to striven for, and engaged in, given the Habermasian position. The goal for Habermas is to make debate as rational as possible. There is a need to be mindful of what and whose values are at play in any given communication, none more so than in healthcare.

3.3 DECISION MAKING IN HEALTHCARE AND COMMUNICATIVE ETHICS

Competent and rational decision making in Habermasian terms pre disposes four validity claims; what we say is comprehensible, true, right, that there is a normative basis to what we say and that it is sincere (Habermas 1981 pp.99 329) (*see footnote 4)*. We can only distinguish between genuine and false consensus if all speakers have equal access to free and unrestrained dialogue – the ideal speech situation. The philosophical notions of truth or defined truths as normative truths will not be argued at this point. The concern is not primarily with semantic construction or pedantic agreement, despite the fact that truth requires expression via statements, but that truth is reached through the force of the better argument and consensus as opposed to 'arbitrary rightness'. He states:

> "I am entitled to ascribe a predicate to an object if and only if any other person who could enter a discussion with me would ascribe the same predicate to the same object...the condition for the truth of statements is the potential agreement of everyone else."
>
> (Habermas in Outhwaite 1994 p.41)

Habermas requires a procedural ethic; the mere fact that a particular norm is accepted by a community as valid does not establish its validity as such. One has to turn to the

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Footnote 4

See Habermas' earlier writing, Communication and the Evolution of Society. Translated by T.McCarthy. Boston: Beacon Press 1979
For a discussion on Communicative action and rationality see Stephen K. White, The recent works of Jurgen Habermas: Reason, justice and modernity chapter 2 pp. 25 – 47. Cambridge University Press 1988.

logic of a moral argument to determine the validity of a norm. The norm that everyone has the right to make her own claims and to criticise others allows for discriminating and regulating influences. Habermas' procedural ethic demands a practical discourse determined by rational consensus.

Taking a traditional doctor/patient interview in which the doctor's agenda and notions of truth and rightness dominate the patient's ideas then it would be difficult to describe such an interaction as a co-operative search for truth. Any valid claims the patient may have are not included in the process. Even taking as read that the level of scientific knowledge, resources and practical constraints are different for most doctors and patients, a Habermasian approach offers some further understanding. Interactive competence in this sense is not to do with these issues alone but rather to enable and encourage processes of mutual understanding, even in difficult situations whilst continuing to participate in communication processes, which are as understandable, right and truthful as is possible and sincerely stated. This ideal cannot always be reached but that does not mean that we should not continue to aim for it in healthcare communication at some level.

Habermas requires communicative action to include any individual who is capable of speech and action to be allowed to participate in discourse, to be allowed to express themselves and introduce any subject or question any proposal. In addition no speaker should be subject to undue coercion or be made to participate in discourse. Adherence to Habermas' rules, in theory, adds to the autonomy of the individual and satisfy basic

communication needs. To this end the substantial move towards increased patient involvement in healthcare must be welcomed.

3.3.1 Patient involvement in healthcare

So far the debate has highlighted the problems incurred through systemically distorted communication and colonisation of the lifeworld. Recent Government recommendations (Kennedy report 2001) and the new NHS Plan (2000) aim to reduce the traditional demarcations between professional and administrative barriers in the delivery of healthcare that fail to acknowledge the healthcare and communicative needs of users. Plans to increase public participation in the organisation and delivery of healthcare have been outlined.

"For the first time patients will have a real say in the NHS. They will have new powers and more influence over the way the NHS works:

- letters about an individual patient's care will be copied to the patient.
- patient's views on local health services will help decide how much cash they get
- patients' advocates will be set up in every hospital
- if operations are cancelled on the day they are due to take place the patients will be able to choose another date within 28 days or the hospital will pay for it to be carried out at another hospital of the patient's choosing
- patient surveys and forums to help services to become more patient centred."

(NHS Plan 2000)

The above recommendations in themselves are interesting (aside from political rhetoric). The recommendation that all patients will receive a copy of the doctor's letter

is not a good thing per se. If the letter is written in codified medical language, then how can this be of any extra value to the patient, unless they are themselves medically trained? Giving a patient a letter in this sense does nothing to reduce the systemic distortion of communicative practice in medicine, but merely ensures the patient has it first hand.

There is increasing emphasis on patient autonomy and active involvement in decision making in healthcare. Recent studies illuminate the complexities of shared decision making in practice (Robinson and Thompson 2001, Montgomery and Fahey 2001, Rakow 2001). And the recommendations above as they stand, although welcomed as they represent a real shift in emphasis toward patient centredness, may still be problematic in practice. As pointed out by Jones:

> "We should not forget that medical paradigms act as major controlling mechanisms for debate."
>
> (Jones 1999)

Jones reminds us of the 'competence gap' in medical encounters, which is reinforced by medical and technical language (Jones 2001). The gap then tends to be filled by distorted communication. Communication theorists from the psychological perspective have noted that when information is lacking or not understood then individuals will make it up themselves. It is simply impossible to leave 'space' in that sense. (Watzlawick 1967, 1978).

The Governments response to involving patients and the public in healthcare is not in their view primarily about investing in structural reforms, but about changing the culture and the way the NHS works, '...so that listening to, and acting on the views of the people who use it become the norm and people are helped and encouraged to make their views known' (DOH, Bristol Inquiry Response, Executive Summary 9.3)

This response to change is not without problems however. Jackson (1999) points out that there are real questions as to whether systems can be opened up to the lifeworld in this way as this still requires the lifeworld entering into the systems world which is formally structured. Although the notion of democratic discourse is to be welcomed there is a danger that movements for change can amount to little other than rhetoric and distributed discourse, but not necessarily distributed resources. Jones (2001) gives a similar argument.

Structural changes at governmental level have been operationalised to underpin cultural and procedural change in health care. The Health and Social Care Act 2001 places in law powers of local government to scrutinise the NHS and that the Secretary of State ensure independent advocacy services are made available to people wishing to make a formal complaint against the NHS.

A Commission for Patient and Public Involvement in Health (CPPIH) is proposed. The CPPIH will oversee the local structures for public and patient involvement and set standards and provide training for public involvement mechanisms. In addition it is

proposed that teams of 'specialist' will encourage and promote public involvement in the NHS (DOH, Bristol Inquiry Response, Executive Summary 9.13-14). The aims of these teams will include picking up community views and that these are comprehensively reflected in local health related decisions and 'patients' journey' data highlights trends across a health economy.

Patients' advocates in the form of Patient Advisory Liaison Services are being widely set up in hospitals across the country. This service has a very different role to patient advocates that work with different cultural patient groups, usually non-English speaking, or mental health advocates. These advocates are usually non-health professionals from the same cultural group as the patients they provide a service for (or in the case of mental health advocates a non-health professional who will support or represent the patient).

"The aims of Patients Advisory and Liaison Services are to:

- Advise and support patients, their families and carers;
- Provide information on NHS services;
- Listen to patients concerns, suggestions or queries;
- Help sort out problems quickly on patients behalf".

(DOH 2003)

By April 2003 ninety four percent of healthcare trusts had patient advisory liaison services (PALS). The Department of Health is currently negotiating a two or three-year research contract to evaluate the impact that PALS has on the patient experience (DOH 2003).

Patients' surveys and forums can only be said to aid rational consensus if the patients themselves are instrumental in the design, delivery and outcome of the structures and processes that are operationalised. What is more, in order to evaluate these proposals against the theoretic framework proposed in the discussion so far any data collated will need to be interpreted and analysed with regard to basic need satisfaction. How far do these proposal go in the aim of protecting health, autonomy and communication needs. To this extent the concern with patient satisfaction outcome measures for example are if the satisfaction relates to health, autonomy and communication needs primarily, not if they relate to subjective wants and desires primarily.

The Government concludes that:

> "For the first time patients and the public will be fully supported in telling us their views; their views will be listened to and they will be influential in making key decisions about the shape of healthcare provision for the future and the way services are designed and delivered on a day to day basis. The strategy we have in place will genuinely place patients and the public at the very centre of what we do."
>
> (DOH Bristol Inquiry Response, Executive Summary 9.15).

This certainly sounds very different to the description of how the NHS has dealt with users need up until now - chapter one highlighted how the NHS developed into an inflexible system often serving it's own needs above those of patients. However, it is unclear at this early stage in the NHS reforms how responsive medicine will be to a more patient led service, or how this will affect the patient experience.

It is also unclear what other structural changes are necessary in the delivery of healthcare to optimise rational communication. It would seem that increasing the

patients' voice is only part of the approach. The onus is on health professionals themselves to critically review communications in healthcare, especially with view to the protection of basic needs of autonomy and communication. The next chapter, therefore, will consider specific consent processes and procedures as a special case for Habermasian analysis.

CHAPTER FOUR

CONSENT IN HEALTHCARE

It will be argued in this chapter that informed consent is important on two counts. First and foremost, informed consent processes respect and facilitate basic needs satisfaction, and secondly in Habermasian terms, it is the rational way to behave.

Habermas has offered a model of communication within which a democratic and rational approach to communication is required for collective and individual purposes. The procedural ethic that underpins this approach makes clear that for communications to be rational and democratic consensus must be sought. Moreover, communications must also protect and enhance individual autonomy. Habermas does not use the language of human rights, but Doyal and Gough have provided a framework of human need, which does use the language of rights and places health and autonomy firmly in the camp of basic needs. It has been argued that communication too is a basic human need and can be argued in the same theoretic terms as Doyal and Gough.

The aim in this chapter is to use consent in healthcare as a focused example for Habermasian analysis using the language of rights.

4.1 INFORMED CONSENT

4.1.1 Moral and legal imperatives

The nature and procedural requirements to meet the needs for informed consent in healthcare continue to be debated. However, treating someone whom has not consented even though capable of doing so is contrary to all notions of respect for that person and respect is widely regarded as the fundamental basis of ethical codes involving human beings (Harris 2003). It is the assumption in most societies that it is persons who are valued most. This is so, despite differences about when persons begin or cease to exist (Harris 2003). The respect afforded towards another is invariably recognised and evaluated in behavioural terms. That is to say it is how an individual treats others, behaves towards them and speaks about them that leads others to decide whether they are respectful or not. There is a requirement to value others, treat them with dignity and consider them as 'being' in their own right, not merely in instrumental terms primarily to meet needs and goals as defined by others.

Harris discusses two dimensions to respect; respect for autonomy and concern for welfare (Harris 2003). Respect for autonomy of persons is one of the notions that separate persons from other animals. We still ought to respect an animal's right to welfare, but we do not, by and large, expect animals to choose between alternatives in the same way we do as humans.

> "Autonomy, the value expressed as the ability to choose and have the freedom to choose between competing conceptions of how to live and indeed why we do so,

is connected to individuality in that it is only by the exercise of autonomy that our lives become our own. By shaping our lives for ourselves we assert our own values and our individuality. Our own choices, decisions and preferences help to make us what we are, for each helps us to confirm and modify our own character and enables us to understand ourselves.....it is because we accept that the meaning, purpose and indeed the distinctive uniqueness of an individuals life is given largely by acts of self definition and self creation that we are concerned to protect those attempts at self creation even where we are convinced that they are misguided or even self harming".

(Harris 2003)

Dimensions of autonomy and welfare should both be taken into account when considering consent in healthcare.

The relationship between welfare, intermediate need satisfaction and personal autonomy so comprehensively explored by Doyal and Gough was discussed in chapter two. The concern with welfare is not just because it is a good or right thing, but because welfare needs require satisfaction in order to allow an individual to flourish and meet the goals of autonomy, health and communication. Discussions about consent in healthcare ought to be primarily concerned with how equipped patients will be to make informed choices about any health related actions and to understand the consequences of those choices on their well being. How decisions affect the way they live their life need to be taken into account. Harris, continues:

"Informed consent is a dimension of respect for persons in that it is through consenting to things that affect us that we make those things consistent with our own values. When we consent to what others propose we make their ends and objectives part of our plans; so far from being merely the instruments of others we incorporate their plans and objectives into our own scheme of things and make them in that sense our own. That is why respect for persons precludes the non-consensual use of other merely for our own benefit and explains why their

> consent to what we propose transforms them from mere tools of ours into self regulating autonomous beings whose chosen path we facilitate".
>
> (Harris 2003)

Although there is little support for not gaining patients' consent, pragmatic difficulties remain when actually trying to gain consent and agreeing about the nature and content of consent. There are both moral (not least to meet the basic needs of communication and autonomy) and legal imperatives to gain consent and for such consent to stand up to scrutiny in terms of validity. (Campbell et al. 1992 pp21-23) suggest that the term consent should be framed as 'informed choice' or 'informed request' as opposed to 'informed consent,' as this more accurately reflects the changing nature of the doctor/patient relationship and emphasises patient involvement in the process. Little (1995) further supports the notion of patient involvement in consent procedures for the very purpose of protecting patients' basic need for autonomy. However, for the purposes of this thesis the terms valid and/or informed consent will be used, as these are the terms most widely used in practice. Little states:

> "Many bio-ethicists regard respect for autonomy as a central medical principle in determining how doctors should act both in practice and clinical research. Informed consent is regarded as perhaps the most important concept flowing from the primacy of the doctrine of autonomy".
>
> (Little 1995 p.122)

Wear (1993) offers four criteria that informed consent ought to meet in order to be legally valid. The first is that the problem or diagnosis for which further investigation or intervention is proposed. Secondly; information about the recommended intervention is coupled with the significant benefits and risks attendant to it. Thirdly; patients ought to

be offered the information about results or prognosis if no intervention is attempted. Fourthly; that information about any significant alternative modalities together with their attendant benefits and risks is forthcoming (Wear 1993 p. 6).

The above factors need to be met to avoid litigation, but the law does not necessarily take into account the effects of illness on personal autonomy. Ethically, these standards are not sufficient, as they do not include understanding on the patient's part. The concept of consent in these circumstances is described as a one-way process whereby the doctor gives information to the patient and the patient then gives written or verbal consent. The doctor appears to have no other responsibility than this. Little and others have challenged this narrow interpretation of information giving in consent procedures. To avoid the consent process being a one sided monologue the patient ought to have an opportunity to give 'feedback' to the doctor. This is described by Faden and Beauchamp as the feedback loop (1986 p.328). A Habermasian position would require the doctor to obtain feedback from the patient to establish mutual understanding and consensus. The patient ought to be able to respond on the level of detail she prefers, providing what Wear calls, 'core disclosure' is included and clarified for understanding. Core disclosure includes whatever choices are available for the patient, what personal or profound sequel of treatment could be, attendant risks, and context of treatment and benefits (Wear 1993 ch.6 pp. 102 – 05).

The situation described here clearly depends on the effectiveness of the communication between the doctor and patient and raises issues of communicative competence as

Habermas describes it, notably with regard to internally organised communication and externally contextualised communication as the next section will demonstrate.

4.1.2 Problems with consent

Empirical studies have shown that the average patient can identify about half, or less, of the information supplied (Robinson and Merav 1976, Bengler 1980, Morgan and Shawb 1986, Roth and Meisal 1981). However, most patients want to be informed and participate in the decision making process and outcomes (Alfidi 1971, Faden and Beauchamp 1980).

Some studies have also shown the significant discrepancy between what doctors think their patients want and what the patients themselves actually do want (Bedell 1984 p.1089, Uhlmann et al. 1988 p.115). There is also some question over the traditional assumption that by employing the processes needed for informed consent, patients' anxieties will be unnecessarily heightened. There is evidence to indicate that this is not the case (Kerrigan et al. 1993). The fundamental principle is not so much *what* patients are told but more about *how* they are told about benefits and risks of treatment. The traditional paternalistic face of medicine has been challenged and a different ethos has emerged.

Although the vigorous pursuit of informed consent may not raise levels of anxiety there is also little evidence to conclude that processes of informed consent increase

understanding. But it could be argued that the patient has not had her/his basic communication needs met. This is not to say that a patient cannot choose to take what the doctor recommends, without reflection or understanding. The moral onus remains with the doctor to act in a way that she knows is likely to improve or maintain the patient's physical health and autonomy, and respect the patient's own internally organised dialogue as valid. Cassell (1977) writes that the best way for a clinician to restore or protect a patient's autonomy is to cure him. However, much of medicine is not about curing but about maintaining and promoting health, and managing illness and disease. In any case, given the Habermas argument that the quest for understanding, mutual agreement and enlightenment is superior to dogmatism then the clinician would certainly fail to meet these demands by concentrating on cure alone.

Wear (1993) argues that in some cases there are times when in practice, informed consent is relatively simple and offers the following example:

> ... "We should agree the values of clarification and counselling are not needed in the prescription of penicillin for pneumonia. Such counselling is, in fact, probably not needed in much of medicine where the physician is comfortable with a given recommendation and the patient willingly consents to it".
>
> (Wear 1993 p. 36)

It may be the case that elaborate consent procedures cannot be upheld for every prescription, or minor intervention, as the health service would grind to a halt. But it could be argued that even in times when the treatment offered is the widely accepted treatment of choice, the patient is still entitled to some information about common problems incumbent with treatment. Gaining informed consent need not be a

complicated procedure in every instance. Even with the quoted example the doctor has additional responsibilities.

The law does entitle patients to basic information about proposed care (including medication), and legally this position is further reinforced by the Human Rights Act (1998). However, in what form and degree informed consent should be mandated for all clinical encounters remains unclear, despite a plethora of recommendations for practice from statutory and professional bodies (General Medical Council 1998, British Medical Association 2001, 2002, Department of Health 2000, Resuscitation Council 2001, Kennedy Report 2001).

So far the arguments for gaining effective patient consent in healthcare have tended to concentrate on the institutional duties of doctors and the information needs of patients. The social context and relationship between the doctor and patient however is important as the doctor takes on several roles when seeking patients consent to treatment. Signing a consent form in and of itself does not constitute consent. The doctor will need to listen to the patient, educate the patient, counsel the patient and respect their views in order to meet the moral and legal imperatives for informed consent.

Having introduced the argument for a moral and legal imperative for informed consent in healthcare let us now turn to the importance and potential benefits of informed consent in principle and practice.

4.1.3 Consent, competence and basic needs

Communication processes, which recognise and enhance patients' basic needs of autonomy and communication, are superior to those that do not, purely on these terms alone. Informed consent implies, at the very least, that there has been some effort to involve the patient in the medical decision making process. This may not always be a complicated affair (take the clearly indicated position of antibiotics for pneumonia). Such a case may be little more than patient authorisation in practice. But more complicated situations require the doctor to inform the patient about complex treatments, alternatives and risks, not only as a legal requirement, but a moral one. The moral requirement is to aim for as much understanding as possible given the patient's ability and capacity to competently participate in medical decision making. There may be a 'trade off' in choices between various therapeutic approaches that have profound effects on patients' lives. End stage renal disease is one such example. Does the patient opt for a renal transplant or continuing dialysis?

It is difficult to envisage how a clinician can make the decision 'for' the patient *(see footnote 1)*. The patient's concerns priorities and values may differ radically from the

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Footnote 1

Exceptions to the rule would be based on therapeutic privilege, the principle of doing no harm and the principle of the patient's best interests. These principles would inform clinical decision making in the light of the patient being unable to communicate or advance wishes are unknown, i.e.; emergency situations and serious threat to life, unconsciousness. Taken and adapted from; Stephen Wear, Informed Consent: patient autonomy and physician beneficence within clinical medicine. 1993 Kluwer Academic Publishers

doctor's. The sociological analysis of health and illness, most especially with regard to the doctor/patient relationship pointed out the notion that there are some things of which only the patient can know *(chapter 1 pages 57-62)*.

Doyal and Gough (1991) discuss the relationship between competence and autonomy and they set out in clear terms the reasons why competent individuals ought to have their right to decision making protected. To rob competent individuals of the opportunity to make decisions about what happens to them, how and where it happens, and what the implications of the decisions are then those individuals are refused the basic need satisfaction of autonomy.

In addition, Habermas states that for rational democratic communicative action to occur, structural and procedural mechanisms ought to be in place which allow for both parties to exercise the moral code for communication. That is, the communication is valid, truthful, legitimate and right *(chapter 3, page 149)*.

The notions of competence and capacity may be argued in legal terms but there is a moral issue at stake. It is surely unreasonable to 'test' every patient's level of understanding in depth, but having said that communicative practices in which consensus is the goal ought to be aimed for. As Habermas argues; it should be recognised that people autonomously choose to participate in medical decision making with various levels of understanding, just as they do in other aspects of their lives. This is despite the effect that disease and illness may have on an individuals capacity to

make competent decisions. Factors such as, pain, anxiety, fear and effects of treatment should not be mistaken for incompetency as such.

Harris argues that competence is not a state of being. That is to say, it is not people that are incompetent but decisions (Harris 2003). A person may be competent to make one decision but not another. Wear, however, argues that competence in clinical decision making is a combination of status and ability (Wear 1993 ch.7 pp.114-17) It could be argued that a person is either competent to manage his own affairs or he isn't; is entitled to the freedom of the community or is not. This means that the person is a free person in a free society and manages with minimal monitoring or impedance (Wear 1993 p. 115). This in itself however does seem a somewhat simplistic evaluation of competence and as Wear himself points out, is not going to suffice in clinical decision making. Therefore simply to be competent or incompetent across the board does not take into account differences of understanding needed for even minimally adequate decision-making in healthcare. Thus ability or capacity to make specific decisions will vary. Wear argues that competent individuals may suffer diminished competence through illness, but by definition these individuals are still seen as competent.

Capacity is likely to be the over-riding concern in healthcare even if individuals are deemed to be competent.

"Its *capacity* component, for its part, insists on the equally important fact that the bare exercise of freedom is not all we are worried about here. Part of the value of being free is that we are able to make our own decisions, evaluate information and options as we see fit, and chart our own course. And a basic

> concern at this juncture is that we know the capacity to do such things may well be substantially diminished in particular situations, including that of illness".
> (Wear 1993 p.117)

Such circumstances call for skilled clinical communication on the clinicians part. Where disease and illness has rendered the patient to a state of significantly diminished capacity, e.g.: severe mental illness, stroke or coma then it reasonable and obvious to clinicians and family members that other means of medical decision making need to be pursued. These situations do not however automatically refer sole decision making rights to doctors, even though they will hold the ultimate responsibility for actions. Just as Habermas suggests, good practice will include discussing choices with patients' families or significant others. Where possible and when known, decisions ought still to reflect patients' previously declared wishes and views and levels of competence at that time (General Medical Council 2002). The justification for any decision reached even when prior wishes are unknown ought to be taken because it is the right thing to do. The principles of best interest and of doing no harm remain of utmost importance. However, that is not to say that beneficial treatment must be given to a patient who has given an advance directive expressing a strong desire not to have treatment as this would be a violation of their known wishes. This becomes even more of an issue if the patients competencies become reduced due to disease progression or acute decline. The General Medical Council has set out standards with regard to good medical practice in response to patients' advance directives, or wishes, if they are known.

> ... "These are statements made by adults at a time they have capacity to decide for themselves about the treatments they wish to accept or refuse, in

circumstances in the future where they are no longer able to make decisions or communicate their preferences. An advance statement cannot authorise a doctor to do anything that is illegal. Where a specific treatment is requested, doctors are not bound to provide it, if in their professional view it is clinically inappropriate. An advance refusal of treatment made when an adult patient was competent, on the basis of adequate information about the implications of his/her choice, is legally binding and must be respected where it is clearly applicable to the patients present circumstances and there is no reason to believe that the patient had changed his/her mind".

(General Medical Council 2002 p.47)

It does not follow however that no treatment should be given. Other forms of treatment, which they have not refused, can be given. Indeed the withholding of any treatment, without their prior agreement could be construed as injury to that person. So although doctors do not have sole rights in the above circumstances, they will inevitably shoulder the responsibility for difficult decisions within interactions with patients, which may or may not increase patients' levels of competency with regard to medical decision making.

4.1.4 Joint decision making in practice

Perhaps, given the difficulties of patient understanding, practical obstacles to gaining informed consent in practice and the not uncommon experience of patients preferring to leave final decision making to clinicians, then there may be a case for returning to the paternalism of the past.

This would be problematic on several counts. While most of us expect doctors to act in our best interests there is evidence that doctors' clinical judgements can be influenced by their own tendency to stereotype patients, most particularly, sociodemographic

characteristics of patients and resource constraints (Richards et al 2000). Despite the move towards greater user involvement in healthcare and the clearly stated duties of a doctor, '*respect the rights of patients to be fully involved in decisions about their care*' (General Medical Council 2001 and 2002) there is little evidence of joint decision making in practice. Some patient groups and doctors are poor at assessing patients' preferences for involvement in decision making in some aspects of care (Bowling 1999).

> "Well they decided,....after they done the angiogram they came back and said that the right coronary was blocked 90% and that they were deciding what to do, whether it would be medication, an angioplasty or open heart. So they decided it was an angioplasty." (Man)
>
> "I think one of the shortcomings is that when you say surgery or pills they don't tell you what the prognosis is on the pills....either in terms of their effectiveness or in terms of their danger. And that is what needs to be addressed." (Man)
> (Kennelly and Bowling 2001)

These conclusions are further supported by others (Robinson and Thomson 2001).

Doyal (2001) argues for the moral necessity of informed consent whilst recognising the difficulties in carrying out the duties in every day medicine. Doyal argues that even when the medical care may well be beneficial, if patients have their right to choice removed then harm is incurred in the moral sense, irrespective of accompanying physical suffering. The harm that is endured 'takes the form of the objective indignity to which the patients are subjected.' (Doyal 1997)

Moreover a return to paternalistic practices would result in over riding patients and families' communication needs and compounding the problems in clinical

communication outlined in chapter one. The potential for informed patient choice demands effective communication and the onus is on the health professionals to lead it.

Research shows that patients can improve their understanding of clinical information, risks and benefits (Edwards and Glynn 2001) and given the moral duty to do so clinicians ought to do their best to obtain informed consent. Patients may make their need for information clear, and may also demonstrate a good understanding of the clinical arguments covered *and* may also make personal decisions which conflict with the clinicians. Their decisions may threaten their well being (Montgomery and Fahy 2001). This being the case the clinician ought to be pretty satisfied that she has been effective in her clinical communication practice, as weak attempts to increase patient understanding, threaten basic needs of autonomy and communication.

So here lies the problem: There is good empirical evidence that effective communication and increased patient understanding improve clinical outcomes *(chapter 1 pages 43-46)* but as has already been noted there is also good evidence that clinicians are not necessarily good communicators. Doyal makes a particularly interesting point:

> "Indeed, the evidence of poor communication in medicine is so widespread that it is unclear what sense to make of the research that suggests that patients are themselves poor recipients of information".
>
> (Doyal 2001)

Effective communication however requires time, resources and training for health professionals, especially doctors in regard to informed consent. The planning and

funding of health care and medical education has a moral duty, given the argument so far to address these issues. If the appeal to address the need for informed consent fails to convince on moral grounds alone then we can turn to grounds of rationality as Habermas does.

4.1.5 The rationality of informed consent

It has been argued that valid informed consent processes demand that patient education is attended to, which in itself demands effective communication. This position can also be argued on grounds of rationality. There is a direct link between effective communication and improvements in cost effectiveness, not just efficacy of treatments (Coulter 1997).

When talking about the rationality of consent it must be clear that we do not mean 'any old' consent, but consent as has been discussed so far. Consent must be obtained via consensus, which has been reached through effective communication. Consent gained on these terms can claim to be valid consent. The validity claims lie not only in the moral and legal duties of clinicians, but also in meeting goals of optimal reason through democratic and undistorted speech acts as described by Habermas.

The Department of Health (2001) published a twelve-point guide to consent and states that obtaining consent is ' usually a process, not a one off event'. This implies the need

for, and role of communication. Additional points clarify the case for effective communication.

> "Patients need sufficient information before they can decide whether to give their consent: for example information about the benefits and risks of the proposed treatment, and alternative treatments. If the patient is not offered as much information as they reasonably need to make their decision, and in a form they can understand, their consent may not be valid....
>
> "Consent must be given voluntarily: not under any form of duress or undue influence from health professionals family or friends....
>
> "Consent can be written, oral or non-verbal. A signature on a consent form does not itself prove the consent is valid - the point of the form is to record the patient's decision, and also increasingly the discussions that have taken place".
> (DOH 2001)

By stressing the point that individual consent should be obtained without pressure or coercion from health professionals in principle is relatively straightforward to understand in Habermasian terms. It has been shown that for Habermas, the two-way flow of democratic communication is crucial for optimally rational mutual understanding to occur. However how attainable are the goals of mutual understanding and consensus in every day healthcare?

4.2 DO PATIENTS HAVE REAL CHOICES?

Patients turn to doctors for help and the codified knowledge and professional clinical judgements that they bring. Detailed presentation of information does not guarantee mature or comprehensive understanding on the patient's part. It will include value laden statements on the doctors part; that is, the doctor may well have a preferred option as a

course to take and may communicate this fact through the selective disclosure of information without even being aware of it. To this extent, their distribution of the process of communication with patients may be "concealed" or systemically distorted in Habermas' sense. Thus, there is a fine line to tread between recommended practice and coercion. Continuing differences in professional recommendations can be confusing for patients. As Wear (1993 p.98) points out: 'It seems inappropriate that a given patient will receive one treatment as opposed to another merely because he is sitting in front of a surgeon rather than an internist.'

The DOH recommendations cited above frame such knowledge as an informing activity. It is something the doctor does to the patient. This does not stand up to Habermasian analysis, as the patient is not being adequately supported to make a real choice. Whereas, if the prime intention of the communication is to reach understanding and mutual consensus, then the communication should concentrate on the activity of choice. The DOH recommendations as they stand do not take into account the personal and possibly profound choices of which only the patient can speak. Without a patient centred element and dialogue that embraces patients' ideas and values it cannot be said the patient has made a real choice. The information giving mode, in contrast to patient centred dialogue which allows for choices, the effect of which, only the patient can know, are mutually exclusive. On the face of it a statement like, 'Giving the patient information in ways that s/he can understand' sound like a good thing. Of itself one would agree. However, one must proceed with caution. The temptation to continue along the doctor led agenda may still be strong; the language may be improved and

jargon free and the presentation of information may be well structured. Yet essentially this process (if it is the only process used) can still stifle direct and democratic interchange. There needs to be explicit intentions to incorporate and encourage patient led components in a consent process for it to meet Habermasian demands.

Equally, the doctor is required to acknowledge, and when possible, act on patient disclosures, in a respectful fashion. These are Habermas' rules. Reciprocal recognition of patient and medical claims require an openness of discourse to allow expression of true intentions with equal chance to express ideas, needs, concerns and expectations. This is indeed a tall order for healthcare systems, medical practice and patients themselves. If anything other than lip service to protocols and recommendations for improved informed consent processes is to be achieved then there is also a need to be aware of the notions of power, distortions, deception and ideology as described in the previous chapter. If not then colonisation of the lifeworld as argued by Habermas will continue and patients' own knowledge validity claims, through their own experience and cultural transmission will also continue to be diminished. Patients' options for real choices will be consequently reduced.

The concern with consent is not for accepted medical practice alone. Patient consent in regard to clinical research has become an issue of societal and medical concern in recent years. The Bristol Royal Infirmary Inquiry (Kennedy Report 2001) came about as a direct result of the outcomes of power, vested interests and distorted consent processes in research and organ retention. The core recommendations in the report focus on communication practices and attitudes. The Bristol and Alder Hey cases (1999) raised

similar points. The Kennedy Report (2001) was the result of the Bristol Inquiry and was outlined in chapter one. The report will be the focus for analysis and the report's recommendations will be considered in more depth using Habermasian analysis.

4.3 THE KENNEDY REPORT

Organisational (as in NHS and institutional communication structures and processes), and doctor/family communications are the major concerns highlighted in the Kennedy Report. For the purposes of the argument the focus will be on the doctor/family components. The aim of this approach is to illustrate in practice some of Habermas' key points. These are specifically with regard to systemic distorted communication and colonisation of the lifeworld.

Recommendations four to nine in the report section (Kennedy Report 2001) 'keeping patients informed about treatment and care,' focus on information needs of patients and families. In particular that information needs should be met in an atmosphere of respect and honesty and delivered in stages, in various modes and reinforced over time. The form of information must be 'comprehensible to patients'. This is indeed in keeping with the most basic requirements for informed consent to take place. These statements in themselves however do not meet the demands of Habermas as this will require more representation from the patient, an engagement on health professionals part and a recognition of the need to involve patients in decisions about their treatment and care. Kennedy stipulates this need in the section 'involving patients'. Here the report states clearly the philosophical shift from beneficent paternalism at it's best, to withholding

information and coercion with vested interests at it's worst, to a sense of equal worth between health professional and patient. The patient is the expert about her subjective experience of health and illness and this ought to be taken into account by the health professionals in order to match their codified knowledge, advice and expertise to match what is important and makes sense to the patient.

> "The notion of partnership between the healthcare professional and the patient, whereby the patient and the professional meet as equals with different expertise, must be adopted by healthcare professionals in all parts of the NHS, including healthcare professionals in hospitals".
>
> (Kennedy Report 2001: Partnership: involving patients rec.: 3)

This philosophy has the potential to be more akin to Habermas in that pathologies generated by the disintegration of collective identity (the patients' lifeworld) through scientization is, at least in principle, acknowledged. It also opens the way for democratic discourse to take place, which requires doctors to account for their actions. However, clarification is still needed as to the value and importance placed on patient narrative or perspective. If the argument in chapter two is returned to, then defining health needs objectively could be problematic in principle. It is not the suggestion here that patients necessarily have the 'final say' or that health professionals ignore their own expertise in favour of patients' ideas or demands. Neither party has free reign to do or demand as they please, other than the patient has the right of autonomy to refuse care, if deemed competent. Both are constrained by the system of health care, codes of practice and socially acceptable behaviours. It has previously been pointed out that patients turn to health professionals for advice and treatment.

The nub of this discussion is the effectiveness of the communications between health professionals and patients. Kennedy points out that health professionals compartmentalise communications into specific tasks, for example breaking bad news or gaining consent (Kennedy Report 2001 ch.23: 34). The result of this can be that anything else the patient or relative raises is considered off the point. This means that the health professional adheres to her agenda regardless of additional patient needs. One can understand how this might come about if healthcare is considered a series of tasks (a form of reductionism again – as the patient is not perceived as a whole but as a series of tasks to be completed in a given time). However as the move toward patient centred care develops further this approach to communication can not be seen as adequate. In addition, it is not effective as it may fail to meet the legitimate needs of the patient. This point will be discussed again in greater detail in chapter six.

From a Habermasian perspective this approach reinforces system conforming roles of the patient as a public client of the welfare state. He goes on to call this 'compulsory abstraction' of everyday life situations, a practical necessity in order that administrative control can be exercised. This way the clients lifeworld is subjugated and their needs are redefined from the system perspective (Habermas 1981 pp.531-34 in White 1988 ch.5 pp.111-12).

Kunneman (1991) interprets Habermas' discussion about dominant models of science and the move towards more informal and 'apparently consensual' or loosely democratic communications as something of an illusion. Solely task-oriented communications as

described by Kennedy are examples of this argument in practice. On the one hand the health professional has an aim of meeting the communication and information needs of the patient, but on the other carries out the communication in such a way that the needs of the patient struggle to remain paramount.

> "The role of communication processes in formal organizations can..... be analyzed more closely if one represents the formal, jurically structured framework of enterprises and state bureaucracies as a 'container' into which communicative processes are squeezed in and damned up. As soon as these threaten to become dysfunctional for the goals of the organization, sanctions which are not communicatively criticizable come into play".
>
> (Kunneman 1991 in Outhwaite 1994 ch.7 p.118)

In the report section 'communicating with patients' nine recommendations outline a protocol for improving communication in practice. Some of which are practical i.e.:

> "Tape recording facilities should be provided by the NHS to enable patients, should they so wish, to make a tape recording of a discussion with a healthcare professional when a diagnosis, course of treatment, or prognosis is being discussed...
>
> "Patients should receive a copy of any letter written about their care or treatment by one health professional to another".
>
> (Kennedy Report rec.: 17 2001)

These recommendations in themselves are all well and good, but if the contents of both are unsatisfactory to the patient, or incomprehensible, then they may be of little practical help for patients. Recommendation 11 does state that the NHS employers have a responsibility to ensure the working arrangements of healthcare professionals allow for them to spend time with patients and encourage them to seek clarification; a Habermasian requirement for collective and institutional responsibility and to meet the

aim of mutual understanding. But has already been noted, even when given the opportunity some patients simply do not take it up for a myriad of reasons. So time in itself will not be enough.

The recognition that anxiety is sometimes created by greater knowledge; that patients need emotional support, and that not all patients need the same level of detail (recs. 14 and 16) are points also addressed in the report. Examples of thoughtless or careless communication with regard to information needs are given.

> ..."We were also told of doctors and nurses drawing diagrams on scraps of paper, or even a paper towel. The sense is gained that informing parents and gaining their consent to treatment was something of a chore".
>
> (Kennedy Report 2001 ch. 7: 7).

It is difficult to imagine the levels of distress parents must feel during a time when their child faces major surgery and the outcome is uncertain. It is also difficult not to come to a conclusion that, at least in this case, the fundamental and basic need for communication could not possibly be met in this way.

The report goes on to recommend more than technical clinical communication competence and includes notions of sincerity, caring and the importance of emotional support as being part and parcel of appropriate health professionals behaviours and attitudes.

> "We are concerned here with attitudes – the frame of mind which the professional brings to the job. The pre-eminent attitude must be that the NHS is a service for the public. The needs of the patients must be the driving concern. This calls for recognition of the need to establish and maintain good communication with patients and with fellow professionals. It calls for a

commitment to respect patients, and to be honest with themselves about their abilities. An attitude of public service also calls for the ability to convey uncertainty without fearing that it will appear weak. It calls for retaining and conveying a sense of open-mindedness in the dialogue which is the patients journey. Perhaps most important of all, it calls for a sense of shared humanity, sympathy, understanding, an ability to engage with the patient on an emotional level, an ability to listen, an ability to assess how much patients wish to know about their condition and treatment, and an ability to convey information with clarity and sympathy. Caring is not just 'what nurses do'. It is therefore what all health professionals should do. In our view, therefore, the attitude of public service which we describe is the essence, the affirmation, of professionalism, not its antithesis".

(Chap 25 rec.: 11)

Over and above this the report is written in the language of rights. This is in complete contrast to the protective and paternalistic tradition of medicine that has flourished prior to and since the inception of the NHS, which has allowed the needs of power bases and vested interests to take precedence over the needs of users.

"Patients are entitled to expect that those who care for them, doctors, nurses and others, will be able to listen, to explain and to communicate with them. Patients are also entitled to expect that health professionals will be able to communicate effectively with each other. Whatever the circumstances, the need for good communication is constant and is integral to good care".

(Chap 23 rec.: 27)

Thereby lies an enormous challenge to institutions of health professionals education and practising health professionals.

"The (medical) profession are removed from the needs of users on an emotional level and because of the very difficult job they do, communication often only stays at a clinical level....Gone are the days where the patient needs to be protected by the profession. Far more account should be taken about what patients feel the need to know..." (Chap 23 rec.: 33)

4.4 DOES HEALTHCARE MEET HABERMAS' DEMANDS?

Informed consent and the role of effective clinical communication have been the focus in this chapter. Other clinical communication tasks could equally have been chosen for Habermasian analysis, taking a medical history from a patient, or explaining a disease or illness to a patient or their family, for example. Given the aims of this thesis it has been argued that the medical systems world domination over the lifeworld has resulted in distorted communication, even in improved consent processes. The power bases and vested interests, namely medicine, the international pharmaceutical industry and government, continue to be influential in medical research and the development of healthcare structures and processes, sometimes at the expense of users. This will be so, even though the motivation may be one of beneficence. Medicine, as has already been noted, has a tenacious grip on its position of power and control. This is ensured even when attempts to redress the balance are made with guidelines for effective clinical communication and information giving in the consent process. Institutional responsibility under the Human Rights Act (1998) will become a firm underpinning of clinical communication issues of consent and it will be interesting to see how this is interpreted in practice. Taking all this into account it would seem in some aspects at least, the idealistic demands of Habermas have not been met in healthcare communications. What is important about a Habermasian analysis is that even if goals are not ultimately attained, the clarification of why problems in communication in healthcare continue from patients and their families' perspective, can be understood. The subtlety of how recommendations from professional and governmental bodies hang on to the power and control through distorted communication by delivering information

from the codified knowledge perspective of medicine in most instances means that even in the case of potentially empowering processes patients are still not truly empowered.

The Kennedy Report goes some way to meeting the demands of Habermas in as much as the patient is the focus of the communication and is entitled to effective communication processes and that vested interests must not over-ride the needs of patients. However, there is no safeguard in the report that really tackles issues about patients' ideas, beliefs and values – the lifeworld. There is still a sense that even though medical paternalism, or more importantly systems vested interests are rejected throughout the report, it is still all about medicine making itself more clear and more transparent about advice, treatment and outcomes from the medical perspective. This is as opposed to encouraging a collectively autonomous public as the main aim. The recommendations, which deal with emotional and subjective experiences of healthcare, continue to be addressed from the professional perspective in the main. How users' views will be responded to or even acted upon when invited to participate in service development and delivery is not made clear. Habermas' notion of democracy is that systemically integrated spheres of action (healthcare) need to be socially integrated (society/patients) through communicatively reached integration, to provide a more balanced form of life (Habermas 1981, in White 1988, p.139).

These arguments are wider than the narrow view of how informed consent is understood in practice. It could be argued that one of the positive outcomes of the Kennedy Report is just this, the report considers consent in the wider sense. In

November 2001 the Department of Health published a new model consent form and policy and patients were involved in the design and testing of the forms which is undoubtedly a move in the right direction if socially integrated change can be achieved in this aspect of medicine.

The idea of equal partnership between patients and health professionals may continue to be an elusive goal in the same way Habermas' ideal speech situation is an ideal goal. The biomedical model of medicine and the disparity of knowledge bases between most patients and health professionals will make this bridge difficult to cross. One thing is clear. It cannot be crossed without the appropriate cognitive and emotional skills on the part of those who are responsible for doing so – without appropriate medical education.

The Kennedy Report recommends the following:

> "Greater priority than at present should be given to non-clinical aspects of care in six key areas in the education, training and continuing professional development of healthcare professionals:
>
> - skills in communicating with patients and colleagues;
> - education about the principles and organisation of the NHS, and about how care is managed, and the skills required for management;
> - the development of teamwork;
> - shared learning across professional boundaries;
> - clinical audit and reflective practice; and leadership"
>
> (Kennedy Report 2001 rec.: 57)

So far, the role of health professionals' education with regard to the problems in clinical communication have not been considered. To this end, the next chapter will describe

how medical education has responded to the problems of clinical communication as have been described and the recent response to reports such as the Kennedy Report and other professional bodies.

CHAPTER FIVE

HEALTH PROFESSIONALS – TRAINING AND PRACTICE

The Kennedy Report, as discussed in the previous chapter, identified communication between health professionals and users and communication between health professionals themselves as the major area of concern. Kennedy recommends the inclusion of communication skills as an ongoing formal component in health professional training and professional development.

> "Competence in non-clinical aspects of caring for patients should be formally assessed as part of the process of obtaining an initial professional qualification, whether as a doctor, a nurse or some other healthcare professional...
>
> Education in communication skills must be an essential part of the education of all health professionals. Communication skills include the ability to engage with patients on an emotional level, to listen, to assess how much information a patient wants to know, and to convey information with clarity and sympathy...
>
> Communication skills must include the ability to engage with and respect the views of fellow healthcare professionals...
>
> The education, training and continuing Professional Development (CPD) of all healthcare professionals should include joint courses between the professions..."
>
> (Kennedy Report 2001 chap 30, rec.: 58, 59, 60)

This chapter will describe the position that communication in healthcare has held in health professional education over the last twenty years or so, especially medicine. It is important to consider the issues over time, as many current (and influential) doctors will have been trained some years ago.

Five main themes relating to education will be considered in this chapter :

1) The problem of reductionism in medicine in as much as it remains a barrier to effective communication

2) Issues in medical education, which are inconsistent with effective communication programmes.

3) Developments in the main approaches to teaching and learning communication and their related problems.

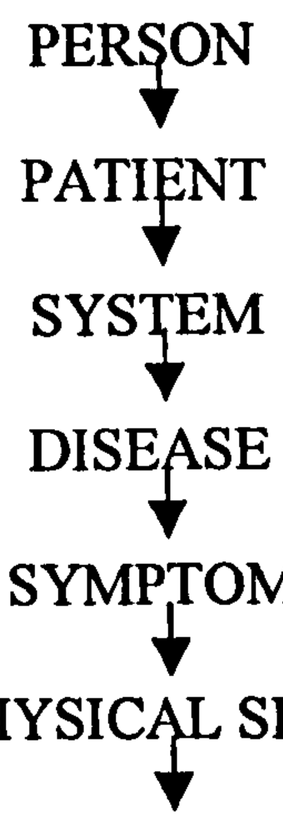
4) Structural factors that influence the provision of effective teaching

5) Where autonomy sits in the scheme of communication teaching.

5.1 REDUCTIONISM IN MEDICINE

The reductionist approach in biomedical practice and education makes communicating with a whole person less likely but makes biomedical sciences easier to manage. In simple terms, reductionism is a way of classifying or categorising something in broad terms or lacking in detail, down to very specific terms, which are narrow and concerned with detail. It is a shift of emphasis, concern and priority. The following figure illustrates the hierarchical nature of reductionism in medicine:

Figure 5.a



"The last 40 years or so have seen a progressive reduction from the whole person with an illness (which is the fundamental unit of clinical medicine) to cellular and molecular biology as the preferred level for scientific medical research. Reductionism has as its ultimate goal the unification of all science within a single discipline, presumably that of particle physics. As Khun pointed out, the success of any reductionist science makes the communication of its content and achievement to non-scientists progressively more difficult. This is particularly unfortunate in medicine, since communication and understanding are essential to the medical transaction".

(Little 1995 p. 37)

The above quote presents a challenge for the appropriate application of medical advancement in a situation when the colonisation of the systems world on the lifeworld has expanded. Teaching biomedical facts traditionally holds high value in medical education and indeed is important. Communicating has been seen as something separate; something the clinician may pay some attention to after the establishment of medical facts and secondary to the biomedical model. This was illustrated in Chapter 1 and Chapter 2 (Rabin 1982, Doyal and Gough 1991). Traditional curricula often commenced with learning basic sciences such as molecules, cells and tissues. First and foremost, it seems, a medical student must learn the skill of reducing the person to a

patient, then further still to a list of signs and symptoms. As soon as medical students learn about diseases, their priorities when gathering information become focused on disease symptomology and functional inquiry. Other aspects relating to patients or the effect illness has on them have been largely ignored. There is some evidence that doctors do not believe that communication training will help, even though dissatisfaction with information gathering is expressed (Cohen 1985). The following quote gives an insight into the way the clinician's concerns and perspective of the patient had been so reduced that he failed to perceive the patient as a human being anymore. His view was that learning communication skills would not have helped him as he was so entrenched in the system of reductionist thinking. However, the clinician did have insight into this. He reflects on some of the tensions that working in a biomedical model can create and demonstrates discomfort and recognition that this was not a 'good' way to be.

> "I was astounded by my behaviour with that patient. Intensive training in interpersonal communications would not have altered how I behaved. Given the time constraint, I dispensed with small talk, barely retaining a semblance of amenity....The focus of my thinking was on the patient's physical signs and symptoms and the physiological reason for them".
>
> (Cohen 1985 p. 332)

The training that doctors have also leads them to believe that if no pathological cause is found then there is nothing 'really' wrong with the patient. There is still the tendency to separate mind and body. If no physical or organic cause for symptoms can be found then it is assumed that the root of the problem is psychological. The patient's physical response to stressors, whatever they may be, may be diagnosed as psychosomatic.

Psychosomatic diagnosis also tends to be valued as 'less real' by practitioners, than is a tangible physiological or functional malfunction. There is an inherent danger in taking this path particularly with regard to gender bias. Women in particular have been subject to psychosomatic labelling. There is some evidence to support the anecdotal experience of women who protest that their doctors do not take their symptoms seriously (Richards et al 2000). As a result women may take longer to present themselves to their doctor with chest pain, palpitations and breathlessness; and when they do they are less likely to be to referred to a cardiologist, and more likely to be labelled as being stressed or anxious. In addition, they are more likely than men to be prescribed tranquillisers or anti-depressants for what may be functional cardiological disorders. These studies showed that this was in contrast to men who are sent off for cardiovascular investigations.

Alternatively, specialisation in medicine can also be problematic as the physician is in danger of reducing or linking signs and symptoms with his/her area of interest at the expense of others. If the patient's diagnostic results do not fit within the repertoire of the specialty then the leap to psycho-somatic conclusions may be taken prematurely. Natelson (1990) gives an example of a woman in her mid-thirties presenting with cardiac symptoms; endless investigations proved no organic cardiac disease. The conclusion reached was that symptoms were due to anxiety, over-reaction and ultimately, depression. Sure enough the woman demonstrated depressive symptoms. However, it turned out that she had a brain tumour and after surgical removal of the tumour her cardiac symptoms resolved. All the accurate highly technical cardiac

investigations proved negative in the woman's case. It was only when her problems were viewed from a different perspective did accurate diagnosis come to light. Specialisation may then complicate the already existing problems due to reductionism because it is a sequele of reductionism itself. Patients may see several specialists to get to the root of a health problem and then have to deal with the resulting information in ways that make sense to them in their particular personal circumstances. If the doctor and patient communicate at the level of signs and symptoms control; a clinical or scientifically oriented discourse that excludes the patient's narrative then 'making sense of it all' is even more difficult for patients.

Engaging with patients on an emotional level is sometimes difficult for doctors. However, patients say this is what they need and do not feel it is unprofessional of health professionals to demonstrate that they feel moved or touched by their plight (Kennedy Report 2001 chap 23 sec 2 rec.: 33 – Humanity). This encultured response can be viewed as protective on two levels. One is professional protectionism and paternalistic attitudes (often misplaced) towards patients and the maintenance of power.

Secondly, and importantly, health professionals may be protecting themselves in their failure to engage with patients and any emotional responses that may entail. One of the hardest things any health professional has to do is to cope with the emotional or physical pain of their patients, especially in difficult circumstances like breaking bad news (Hajek et al. 2000, Dosanjh et al. 2001). Learning a set of techniques to do this is in itself not enough. Further required is support for the doctors or nurses themselves.

It is common and desirable for health professionals to develop relationships with their patients, which involve respect and sincerity, as well as the desire to help with the presenting disease. It is not always possible to go onto the next patient with a shrug of the shoulders, - a metaphor for ridding oneself of the distress. These issues are not really addressed, even though there cannot be a health professional in living memory who has not had to deal with his or her own self in difficult circumstances. In general, communication training does not deal adequately with the perspective of 'self' and professional support for communication issues (Dosanjh 2001).

Another effect of reductionism is that of professional detachment, that is, not engaging with patients and relatives other than to discuss signs and symptoms, diagnosis and prognosis is encouraged through the use of technical and medical jargon. Medical discourse excludes patients and requires health professionals to repress, ignore or shut out their own human emotional responses to their patients' distress in order 'to get on with the job'. Reducing patients to signs and symptoms or even a histopathology is a very efficient way of ensuring professional detachment. The question is - is this a good thing? There is some evidence to support the argument that medical education, culture and practice are harmful to doctors' own well being and mental and emotional health (McKegney 1989).

5.2 ISSUES IN MEDICAL EDUCATION WHICH ARE INCONSISTENT WITH EFFECTIVE COMMUNICATION PROGRAMMES

In this section some aspects of medical education that are inconsistent with developing learning in communication skills will be outlined. As chapter one has shown, there is evidence to support the view that medical education does little to facilitate communicative competence either from the Habermasian notion of collective consensus and rational discourse, or at a pragmatic individual level. Despite advances and emphasis on patient-centred medicine problems in this regard remain (Levenstein et al 1989, Roter and Hall 1987). Beaudoin et al (1998) showed in their study that junior doctors declared that their teachers failed to show positive humanistic qualities and often seemed unconcerned with their patients' psychosocial adaptation to illness. Furthermore, teachers did not try to understand the difficulties for students that this raised, or offer support.

There is further evidence that medical education structures and processes are damaging to both doctors and patients. It can be damaging to doctors' wellbeing and it can be damaging to patients because of the predominately reductionalist approach to patient management as discussed in the previous section and by others (Guthrie et al 1998, Bligh 2000). Novack (1997), among others, notes the demise of the humanistic aspect of medicine as scientific discovery expands possibilities in technological approaches to medicine. This is indeed entirely in keeping with Habermas' argument of colonisation of the lifeworld. The devaluing of the clinical encounter also results in poor satisfaction for the doctor (Bligh 2000, Gerrard and Riddell, 1988).

Medical students and junior doctors do not, however, just have to meet the communication and health needs of patients; they also have to do well in the eyes of their consultant or superiors. They may not get the support they need, as has already been shown (Beaudoin et al 1998). Habermas' idea that enlightenment is superior to dogma is not, in the main, the case in medicine. Young doctors have to learn that Dr. A likes to have X happen to his patients, but Dr. B likes Z to happen to his. Rituals, procedures and preferences in terms of practice and education may be held as a result of the dogmatic whims and personal preferences rather than informed reason.

McKegney provides the argument that medical education is analogous to an abusive and neglectful family system and in effect does not help clinicians to meet the basic need of personal autonomy in their students or patients:

> "The family of medical education often behaves in a neglectful and abusive fashion. It isolates itself from support and consultation, rigidly maintaining the training structure passed down from generations. ... Secrets about inadequacies and mistakes are hidden or shared inappropriately. ... Male or female physicians are trained to be authoritative, independent, decision-makers. By accomplishing this independence, physicians inherit the isolation and indirect communication patterns of their predecessors and the cycle begins again".
>
> (McKegney p. 1989)

Other studies have come to the conclusion that medical education has damaging components and is currently unable to support communication training in a congruent way (Kahn et al. 1979, Kern et al. 1989, Maguire 1984, and Simpson 1972). Health professionals are human like any body else and will fall prey to the results of stress.

Clark and Zeldow (1988) found that 12% of one medical school class had considerable depressive symptoms during the first three years of medical school.

The situation appears to be even worse for house doctors and senior house doctors (Firth-Cozens 1987). This picture is mirrored in North America (Butterfield 1988). The stressful conditions do not relate to long hours and pressure of work alone. It is more to do with the nature of the work. Bark (1997, personal communication) carried out a study which identified how mistakes are dealt with in the system and showed that there was little opportunity for feedback and learning for junior doctors. Junior doctors were approached at random and asked if they had made any mistakes in the last year and how they had responded to them. Most did nothing and kept it to themselves. Some demonstrated psychological and emotional distress behaviours, felt unable to share the problem with anyone, had lost sleep, the mistake stayed with them and had not been dealt with in any constructive way. Other studies have shown that junior doctors perceive a lack of support (Garrud 1990) and training (Dale 1999) and that in both these instances doctors suffer high levels of psychological distress.

The system itself does not value the importance of human communication in healthcare, even in the light of evidence that effective communication has overwhelming benefits, as discussed in chapter one. Medical students have to take on the values of the medical system, become socialised into it and conform, if they are to succeed. That is not to say that enlightenment does not hold up for some in the end.

"After several years of study, I thought I understood what medicine was all about: learning the scientific facts so that when you saw what was wrong inside your patients with your physician x-ray vision, a knowledge of the facts would permit you to heal them - in fact, this is what many doctors - and most of the public believe about medicine as well. .... I realised later that this view is quite wrong".

(Shorter 1985 p.3-14)

Here is the dichotomy: medicine is essentially reductionist, but the human condition does not 'fit' into this paradigm. Reductionism has its roots in determinism, and at the level of cells and molecules this may be appropriate. But once we start to climb the hierarchy of systems this approach needs to be modified or transformed. Hermeneutic interpretation and analysis may be more helpful as a hermaneutic approach includes acknowledgement and validation of meaning which can only be attained by effective communication. A hermeneutic approach is more to do with interpretation and understanding on a pragmatic level rather than the traditional scientific method and measurement. Currently there is little evidence that medical education attends to the need to translate or transform information at the cellular level to the pragmatic level of understanding in order to communicate effectively.

Medical education is intellectually challenging but actually changes people and there are risks involved, least of all in terms of doctors' own emotional and physical well-being (Konner 1987 p. 373-374). Some research shows that empathic responses in medical students tend to be reduced during the course of their medical education. However, there is other evidence that refutes this. Maguire et al (1996) showed in a five year follow up study, that if students were offered interview skills training general interview skills were retained. It was noted that there were still some deficiencies, but in

areas that had not been included in the original training. Higgins (1990) also showed that if exposed to empathy training students not only demonstrated an increase in their empathic skills, as evaluated by students, patients and observers, but they also showed a significant reduction in perceived stress when confronted with emotional issues when interviewing patients. However, surveys reveal that the health professional-patient relationship is the one area that junior doctors (for doctor, also read nurses) feel least competent in and which causes the most stress and anxiety (Gerrard, Boniface and Love 1980, Graham et al 1996). Working in the current health system is stressful; patient throughput has increased; waiting lists remain, and even though junior doctors' hours have been reduced, most work a punishing schedule. Health professionals need care and support to deal with their own stress in order to be able to deal with others.

Communication training must take into account the needs of those being trained as well as learning about communication skills. One of the aims of good communication skills training is that the students will become more aware of their own communication and develop a responsible attitude about the effect of their own communication (Roter et al. 1990). This entails more than going through a set of techniques in a prescriptive fashion. Understanding the process of employing a skill and the theory behind the communication process are points that should also be covered. Roter's study, for example, showed that an intensive training course which incorporated the psychosocial domain of medicine into interview skills training led to positive changes in residents' self awareness and attitudes.

Awareness and understanding about communication, needs to be reinforced throughout a health professional's career. Starting at undergraduate level and continuing through the ranks. When this happens it would seem a reasonable assumption that health policies around communication issues can be formed and agreed upon. It is also a reasonable assumption that the benefits mentioned in chapter one would be met as well as a marked reduction in dissatisfaction and complaints. Calnan (1991) lists important 'items' of expectations that patients tend to have. When these expectations are not met, complaints may follow. These all pivot around effective communication and respect for individuals. Most of them are non-verbal, facial expression, mode of dress, handshaking, a respectful attitude and sense of trust. Kindness and trust can be conveyed with virtually no spoken words. Let us be clear that effective communication is more complex than merely being nice to each other. Doyle, Gough and Habermas have provided a firm conceptual base from which to approach effective communication in healthcare – that is the notion of needs based morally and rationally argued action to protect and enhance autonomy. This thesis has also included communication as a basic need on the same theoretic grounds. So how far has health professional education come in meeting the communicational needs for learners and patients?

5.2.1 The history of communication skills educational development in medicine and nursing

This section addresses the picture over recent years in terms of teaching communication skills to health professionals. Developments over the last twenty or so years to set the context for today's problems will be briefly outlined.

The position of communication skills training in UK medical schools in the seventies was very poor (GMC 1977, Fletcher 1979). Around a third of all medical schools offered no communication skills training. Some senior members of medical schools were in fact positively against the idea of teaching the subject. What was being offered was *ad hoc* and poorly evaluated. By the mid-eighties little progress had been made in terms of organised teaching of the subject (Kerr 1986). Wakeford (1983) outlines several reasons why more was not being done. Personal attitudes and values played an important part. Negative factors included poor communication about the actual teaching and the rationale behind the teaching. The technical support required for success was also unclear. Unrealistic or poorly thought out time scales for review meant that the subject was not taken seriously as a competing subject for inclusion in undergraduate curricula in some schools (Wakeford 1983). The demands of the medical curriculum continued to pose problems in terms of, on the one hand, education, and on the other, vocational training. One argument raised was that difficulties and conflicting demands are presented when most of the teaching is carried out by medical staff employed by the NHS as opposed to the educational establishment. Variation in teaching quality could be wide and actual control in terms of what is taught can be small.

The situation with respect to nurse education has also been wanting. Nurses are not constrained in quite the same way as doctors by their educational approach. Traditionally nurses have included communication under the umbrella of social or interpersonal skills. Nursing itself is an interpersonal activity, and in that sense, is a communicative activity. There are still persistent recommendations from researchers

that interpersonal skills ought to be included in basic and post-basic education. It is a common assumption that nurses are better at communicating than doctors (*see footnote 1*). There are many examples where this is not the case (Maguire, 1985, Macleod -Clark, 1985, Walton and Macleod -Clark, 1986, McIntyre et al., 1984, McCartan and Hargie, 1990). *'Professional validating bodies are beginning to express concern over nurses' ineffective use of interpersonal skills.'* (Kagan et al. 1986).

Nurse's survey findings (1977) mirrored the medical schools. Twenty four schools of nursing were invited to participate in the survey. This was an attempt to establish the position of communication training in nursing education across the UK. Of the fifteen schools that responded only two confirmed that communication skills teaching was taught as specified sessions. Otherwise, the picture revealed that communication was more likely to be discussed implicitly in relation to other areas of nursing practice. Things did not improve significantly in the eighties. Faulkner et al (1983) and Gott (1984) found that commonly no formal teaching of communication skills was provided. Where teaching was provided, teachers were generally ill equipped to deal competently with the subject matter. The overall picture of nursing education in England, Wales and Northern Ireland was that 5% or less of the curriculum time was offered to planned

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Footnote 1

Multidisciplinary learning

One of the most disappointing and persistent failures of the recent advances in communication skills training is the singular lack of consistent, formally recognised and organised joint multidisciplinary learning, most specifically for medicine and nursing. Co-operative arrangements have been advocated and discussed by others (Pendleton et al 1984; Ross and Southgate, 2000; Kagan 1985). It would seem that to help solve some of the resource issues, especially in relation to availability of tutors and expertise, it makes common sense to nurture interdisciplinary collaboration. In reality though examples of such collaboration are hard to find, tend to be ad hoc, or on a 'one off' type of basis.

Communication sessions. Eastwood (1985) recommended that for further improvement in communication skill development to occur there was a need to:

- train the trainers in the teaching of these skills
- provide a more structured approach to learning for students
- equip training centres with the modern resources required to teach these skills.

Others highlighted the need to bring together the issues of research, practice and education in relation to interpersonal skills in nursing (Porritt 1984, Sundeen et al. 1985, Kagan et al. 1986).

It is important to take into account the last twenty years, because those students are the consultants, teachers, nurses and practitioners of today. They may or may not have had post-basic or postgraduate training to 'fill the gap' in order to meet current clinical communication recommendations. Their practice and values are what today's learners and patients will be subject to.

The rather depressing summary offered by Davis and Fallowfield (1991) listing common deficiencies in professional communication skills, as outlined in chapter one, indicates the lack of consistent and comprehensive development in health professional education for doctors and nurses.

5.3 DEVELOPMENTS IN THE MAIN APPROACHES TO TEACHING AND LEARNING COMMUNICATION AND THEIR RELATED PROBLEMS

Although, at the present, the amount of time allocated to teaching and learning of communication skills has increased in many medical schools, it is still considerably smaller than other parts of the curriculum, and remains problematic (Fallowfield 1993). Traditionally technocentric doctor-centred approaches remain common, and the importance of a biopsychosocial perspective is often paid lip service only (Engel 1977,1980). The situation has not changed to any great extent according to more recent research (Hargie et al. 1998). It is difficult to say however, what the balance of time allocated to communication curricula should be, and a debate continues to be held. The primary aim of the teaching and learning is to produce safe, competent ethical practitioners as defined by professional and statutory bodies.

The approaches covered in this part of the discussion are used for both doctors and nurses with some difference in emphasis. The emphasis for any given approach, concept or skill is dependent on context. At this point it may be helpful to acknowledge this, so as to avoid lengthy discussions on the variable of context. Let us look at three common approaches to teaching and learning communication skills. The first approach focuses on the generation of skills honed through experience - the idea that being in the job means health professionals have the skill, and become more effective with experience. The second highlights the importance of mentorship and modelling; and the third underlines the importance of formal or directed learning.

5.3.1 Experience

There remains an erroneous belief that communicative competence will come with experience. The empirical evidence to support this view is scant. In practice, it is unreliable and individuals can be doing a job for years and never discover or demonstrate the right interpersonal skills (Argyle 1983). Dickson, Hargie and Morrow (1989) highlight four obvious weaknesses in this approach: Learning is predominantly by trial and error. The learner may develop habits of 'survival' rather than situationally appropriate strategies and skills. The learner may be unable to cope in certain situations or cope at the expense of the patient or indeed themselves. This position raises profound ethical issues about the learner's own wellbeing as well as that of a patient. There is no structure for providing feedback to the learner, thereby denying the learner opportunities for learning and development. A short-term pay off of survival may result in long-term problems for self and patient. Ineffective or harmful communicative practices can be perpetuated and unchecked.

5.3.2 Mentorship and modelling

This is a method of learning whereby an experienced professional takes individuals 'under their wing ', so to speak. It is a relationship of master - novice. Many medical and nursing colleges incorporate this apprenticeship method into both undergraduate and postgraduate programmes. It is certainly a useful addition to any learning programmes, but like any method not without problems. Maguire (1981) points out the main

difficulties to be aware of. The notion of 'master practitioner' is in itself a problem. Even experts have bad habits and make mistakes. There is no guarantee that the learner will identify the subtleties of effective performance and discriminate between that and inappropriate ways of relating. Particular difficulties may occur in modelling when there are marked differences between the experienced professional and the student in, say, cultural background, personality, attitude, age, sex and behavioural style. It may promote conservatism and can militate against innovation. There is no guarantee that the expert is familiar or conversant with the research and literature on factors that enable and enhance effective communication in healthcare.

However, the power of the role model is significant and can promote good or bad practice in what ultimately becomes a 'hidden curriculum' and can support or undermine formal communication teaching and learning (Sears et al. 1991, Pfeiffer et al. 1998). The learner can be under increasing covert or overt pressure to develop their practice as modelled by the role model. When this practice does not conflict with the ethical principles of furthering the health and autonomy of patient (and learners), does not encourage systemically distorted communication, and encourages rational discourse between patients and learners, then it is unproblematic. The modelling or mentoring process implies there is a relationship between learner and teacher which encourages debate and conscious growth. When this is positive it can be a rewarding experience for the learner. It is when it is not so that there are problems. The learner is put into a double bind situation whereby she experiences conflict. Does she behave in a way which pleases her mentor but conflicts with the ideals and principles of ethical clinical

communication, or does she raise these issues with the mentor? It is an uncomfortable position to be in, especially for a learner who may feel worried about the effect of any perceived challenge to a superior's behaviour might have on the working relationship, assessment grades or references. In his anthropological study of medicine, Good (1994) quotes a student's own words reflecting his experience in clinical medical education with regard to the role the senior clinician has in validating the system:

> '"*..my impression is that if you really respect that person, then you tend to feel a lot more comfortable with the whole system, and the arbitrary aspects and the times when people seem to be acting by convention versus from proven data or whatever don't make you feel as uncomfortable. But if the guy at the top is someone you don't respect or something for whatever reason, which has only happened to me once, you really start to think, at least for me, feel very kind of ill at ease with the whole kind of enterprise.*" '
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> (Good 1994 p. 83)

5.3.3 Formal or directed teaching and learning

Methodologies can be broadly grouped into a) cognitive learning and b) group work which has more room for experiential learning.

a) Cognitive learning

This approach tends to take place mainly in the classroom or lecture theatre and favours traditional didactic techniques. The general aim of this approach is to increase interpersonal functioning. But it may consist of a disparate collection of techniques which are less likely to result in positive behavioural change in themselves, although do have some advantages. Phillips and Fraser (1982) classified these techniques into,

thinking, feeling, or doing in their orientation. This is a useful methodological classification.

The weaknesses inherent are:

- There is little or no opportunity to practice or develop communication skills.
- Learners can remain unaware or fail to understand the desirability of personalising the knowledge.
- There may be a high level of dependence on the trainer. Complimentary dimensions of communicative competence may be inadequately addressed.
- The lack of personal ownership can lead learners to believe that communication is something that they do *to* someone else.
- Worse still communicating is thought of in such a dissociated way it can be categorised as separate activity or model of human behaviour as opposed to the more desirable approach which argues communication as an integrated human activity.

Phillips and Fraser (1982), Dickson et al (1989).

Advantages may be:

- The thinking approach to learning about communication is certainly intellectually challenging and this may be a very attractive option for some.
- It is often provided as a lecture or presentation, or seminar groups that might include videos to watch and discuss and is easier to resource than small group interactive sessions.

- It is likely to be non-threatening and require little personal association and high levels of detachment. Learners will be able to remain passive in their assimilation of facts and knowledge about communication.

b) Group work

Group work may combine both personal awareness and skills practice and tends to focus on how the learner and 'patient' feel about their encounters. Methods that focus on feelings concentrate on the affective component of communicating. Groups may consist of experiential learning groups and sensitivity training groups. Broadly speaking, the aim of learning about the feeling component of communication is to raise awareness. Individuals may be encouraged to 'share' personal experiences and feelings and will be subject to feedback from others in the group. They tend to be less structured and work with what is presented; there is less of a pre-set agenda and the tutors can work with the learners' material. The advantages of this type of learning are that individuals will identify at the most personal level with emotional components of communication and may well become more aware of the impact communication has on peoples everyday lives. However, pitching the level of association into personal experience so as not to be threatening, distressing or harmful for learners may be difficult. Skills of trainers are important in group work. The expectation that individuals will divulge or share experiences in an honest way may not be fulfilled, and the subject matter may be presented independent of any conceptual framework. A lack of structure can lead to dissatisfaction on the learner's part and may mean that learning objectives are not agreed.

There is the tendency to suggest that 'feeling' is always the most important part in communicating. This is a particularly interesting point. Due to the influence of the humanistic approach to communication in healthcare, health professionals have placed considerable emphasis on the concept of 'feeling', perhaps as a reaction to it's almost total lack of inclusion in many doctor/patient encounters. Patients may be asked how they feel. However, asking someone how they feel does not in itself mean that they will divulge their feelings. If patients do not ask questions even when given the opportunity in consultations then it may be overly optimistic to expect them to divulge their innermost feelings. A successful interaction of such an intimate nature requires significant relationship skills and time and a relationship based on trust and genuineness.

Having said all of this, it is does not follow that there is a competitiveness of value between emotional and cognitive aspects of communication, merely the need to differentiate what is most helpful for the patient. The patient-centred concept of finding out patient ideas, concerns and expectations has been shown by Tuckett et al (1985) to be important in developing rapport and increasing the likelihood of positive outcomes in consultations. This approach will provide information about a patients thoughts and feelings in a more sophisticated and subtle or gentle process. But there will be times when the last thing a patient wants to do is to verbalise or expose how they feel directly. Health professionals also need to be able to deal with patients and relatives responses when they have elicited them. The 'doing methods' of learning can be of particular value in this regard.

The 'doing methods' of training rely upon techniques such as role play, observing and participating in practising skills and focus on what people actually do when they are communicating. These are aimed at levels of behaviour and capability and can illustrate in practical terms examples of communicative competence or incompetence. The drawbacks are that learning can take place about behaviour, but in a vacuum, in as far as 'the why' of any given behaviour can be neglected unless the objectives for the interaction are clarified with the learner. What the learner is thinking or feeling and her/his goals in communicating are important components of learning. There is a danger though that there may be more emphasis on trainees behaving or performing, than on actual understanding and learning. This is a danger inherent in any programme which does not provide a firm conceptual theoretical base to inform any subsequent activity. Theoretic bases for communication skills training will be considered next.

5.3.4 Communication skills training: examples of models

To understand communicative processes is no easy task and when we talk about communication skills this implies an operationalisation of communicative processes. Skills-based models are gaining favour in communication training in healthcare. Such models demonstrate that although communication in healthcare is fraught with difficulties, it is possible to do in a methodological and organised way. This may make the idea of training of this type more attractive to skeptics who believe it is woolly, touchy-feely and impossible to evaluate. Dickson, Hargie and Morrow (1989), Cole and Bird (1991) and more recently Kurtz and Silverman (1998) offer guidelines and

frameworks for skills-based models for communication training in healthcare. These include references to research and understanding about communication processes and attitudinal approaches to avoid the dangers of approaching skills in isolation, as mentioned in the previous section. They are examples of how practice can be taught and organised.

The Dickson, Hargie and Morrow model comprises five main phases, these are: identifying skills, raising awareness, skills practice, feedback and evaluation.

The first phase involves identifying common skills, (see fig 5.b). In the second stage, sensitization is essentially about raising levels of awareness and understanding about the nature of the training and the skills involved. The learners will also be expected to show some degree of analysis and discrimination in regard to specific skills. The third phase is putting into practice skills and concepts considered in the first two stages. Techniques for practice are; the use of role play, exercises and games, 'in vivo' practice, or practice in the clinical setting. Fourthly, the feedback phase includes the use of video, audiotape, oral and written feedback. Feedback can be given by the tutors, peers and participants in the course. Finally, evaluation of the training considers validity and reliability of the test instrument used and ought to include evaluation of the tutors and teaching methods by, for example, the use of rating scales and learner outcomes. Methodologies to assess outcomes include direct methods of observation and indirect methods of examination such as written tests, oral tests and project work. *"Regarding communication as skill implies not only that instruction can be planned, executed and*

evaluated but points the way to the sorts of training methods which may prove suitable". (Dickson et al. 1989 p. 22).

Figure 5.b

Core communication skills

- listening
- creating empathy or rapport
- nonverbal communication
- explaining
- opening and closing
- questioning
- checking for understanding - reflecting
- reinforcing
- influencing
- assertiveness

Cole and Bird (1991) use the medical interview as the sole focus of their communication skills training and concentrate on what they describe as the three functions of the medical interview. These are: building the relationship, assessing the patient's problems and managing the patient's problems. Their approach to teaching and learning is primarily through experiential role play sessions. Cohen-Cole, Bird and Mance (1995) outline a ten-step approach to role-play teaching.

- Clarify the objectives of role play
- Demonstrate relevant techniques
- Define the clinical situation: spontaneous role play approaches
- Rehearse patient role
- Rehearse doctor role
- Role play

- Feedback 1: Doctor's analysis
- Feedback 2: Patients response
- Feedback 3: The instructor and audience
- Repeat role play

This model requires learners to take on the role of the patient. The authors talk about students taking on for example, a role of an elderly widowed patient. This has inherent difficulties in as much as this requires a performance on the student's part. This is compounded by the language used. In feedback the group is called the audience and students are asked how they feel about 'playing the doctor' (Cohen-Cole, Bird and Mance chap 34 pp. 407-8). This could have the effect of taking away credibility from the experience. Complications such as a young person playing an elderly person, or of a different gender, culture etc. could be problematic. It could be argued that by introducing performance into the learning setting takes the focus away from the skills that are actually being practised. The authors do state that real or simulated patients can contribute to role play but make no critical statement about their view on which approach is more favourable.

An alternative approach which benefits from the advantages of role play as a learning methodology does not require the students to 'act'. Students remain themselves in any given clinical situation practising their skills and learning about how they personally, given their current level of training, respond to the patient, or relative. This ensures the focus of learning is on self-reflection and personal growth and not confused with acting

skills or performance. Real or simulated patients (usually trained actors) are commonly used in this approach and Kurtz, Silverman and Draper (1998) tend towards this approach.

The above two models have undoubtedly paved the way and led communication skills training in medical education in the earlier years. Integration of communication skills learning into the wider medical curriculum was still some way off in many medical education institutions.

Kurtz, Silverman and Draper (1998) provide possibly the most comprehensive skills-based approach taking into account the *why? what?* and *how?* of communication skills teaching and learning. The authors include three fundamentally important points. First, the need for integration of learning into clinical practice. Second, communication is a core clinical skill and, third, and equally important, evidence-based teaching and learning. By encouraging an evidence-based approach and referring to research and theory, Kurtz et al. strengthen the validity of communication skills teaching. Their approach is developed around the medical interview and a medical interview guide for teaching and learning is described. The *'Calgary - Cambridge Observation Guide' has* 70 criteria or skills (p.23 - 26) and two further guides are offered: *'Interviewing the Patient'* has 33 criteria, and *'Explanation and Planning'* has 40 criteria (pp.226 - 231) *{See appendices}.*

Kurtz, Silverman and Draper also argue that teaching skills alone is not sufficient and offer a helically structured framework based on Dance's model of communication (1967). That is to say subject matter is introduced, reiterated, reinforced and spirals round at a slightly different level each time. Research evidence is referred to opportunistically in sessions.

A development and advance with the Kurtz model over the Dickson model was the explicit attention given to shared decision making (Kurtz, Silverman and Draper 1998 chap 5 pp.115-24). This is important because of the relationship between decision making and individual autonomy. Although the authors do not develop this idea explicitly in their model, much of their writing and explanations of the advantages of shared decision making in clinical encounters do allude to notions of empowerment, respect and acknowledgement of patients' own contribution to the consultation as being valid and useful. The language of rights is not used but it is clear in their approach that the onus is on the doctor to develop appropriate communication skills to increase a mutually consensual doctor/patient relationship as opposed to a paternalistic one.

The models described above are examples of how communication skills programmes could be organised. They encompass preparation, training and evaluation phases. Hargie et al (1989) do conclude that contextual realities of communication skills training must be realised and that it would be naive to expect communication training single handedly to solve all the problems of communication in healthcare. However, the potentially enormous positive contribution of effective communication in healthcare

curricula to healthcare provision are not in the main realised, as recent research has shown. These models do present useful ways of formalising curriculum content, method of delivery and assessment of competence.

5.4 THE OVERALL CURRENT SITUATION FOR COMMUNICATION SKILLS TRAINING IN UK MEDICAL SCHOOLS

A range of teaching and learning has been shown to result in positive change and development in learners, (Carroll and Munroe, 1979, Maguire et al. 1978) (*see footnote 2*). Although there is relative lack of longitudinal studies. Hulsman et al. (1999) did review fourteen postgraduate training studies, which showed that interpersonal and affective behaviours improved. However, only three of the studies included pre and post test and control groups, which may weaken the reliability of the outcome data.

Footnote 2

Teaching methods used to bring about changes in learners' communication skills:

Rutter & Maguire (1976)	*handouts, video/audio, real patients, feedback*
Irwin & Bamber (1984)	*video/audio, real patients, feedback*
Evans et al. (1989,1991)	*lectures, video/audio, real patients, simulated patients, role play, feedback*
Stillman et al. (1976,1977)	*video/audio, simulated patients, feedback*
Stanson-Fisher & Poole (1978)	*training workshop*
Putnam et al. (1988)	*handouts, workshop, video/audio, real patients, feedback*
Joos et al. (1996)	*handouts, lecture, workshop, video/audio, simulated patients, feedback*
Goldberg et al. (1980)	*video/audio, real patients, feedback*
Gask et al. (1987,1988)	*handouts, video/audio, real patients, feedback*
Levinson & Roter (1983)	*handouts, lecture, video/audio, real patients, simulated patients, role play, feedback*
Inui et al (1976)	*training workshop*
Roter et al. (1995)	*handouts, lecture, workshop, video/audio, real patients, role play, feedback*

Adapted from: Teaching and Learning Communication in Medicine. Kurtz, Silverman and Draper, Radcliffe Medical Press, 1998

But poorly structured or ill-conceived communication skills training without a theoretical base is problematic. Fielding and Llewelyn (1987) and Roberts and Fallowfield (1990) further validate this. Attending a 'counselling skills or communication skills' course for a couple of days, as part of in-service training, do not qualify any professional to make claims other than having attended the course. If they are set in isolation and not integrated into clinical skills training or professional development in a clinical sense then the problem of relating learning to practice is greater. There is also a wide variation in the training and quality of the teachers. One of the difficulties in establishing the value of communication skills training is that there is insufficient published data debating the impact on communication skills training on further learning or practice.

A recent survey considers in more depth the current situation in medical schools shows that communication skills teaching varies widely in terms of quantity, quality and content throughout medical schools in the UK (Hargie et al. 1998). A detailed survey of twenty-six medical schools and universities in the UK resulted in nineteen completed returns. In many instances the findings replicated earlier studies as referenced, and in particular the study by Whitehouse (1991). The problematic position of communication in healthcare remains despite the recommendations of the General Medical Council (1991, 1993, 2000), the World Federation for Medical Education (1994) and the British Medical Association (1998).

Currently the estimated amount of curriculum time devoted to communication skills training varies from 5% to 25%. Although it is not entirely clear what constitutes the training. This is a remarkably wide margin. Students may receive anything between 3 and 16 communication skill sessions throughout the duration of a course. Consider a difference of this degree if the subject was, for example, surgery. And the course content can differ markedly from a skills-based focus on the one hand to a thematic approach on the other. Thirteen of the schools incorporate a theoretic component to underpin communication skills and fifteen integrate theory and practice. Theoretic components reported include; attitude theory, social interaction, the psychology of group behaviour and group dynamics, cognitive aspects of communication, 'compliance' and medical ethics. The authors concluded that a significant group of students are subject to unbalanced or inadequate communication training programmes.

Teaching methods also appear to be diverse in range and priority. Most common are role play with actual or simulated patients and lectures. Less commonly tutorials, modelling, seminars, workshops, interactive videos, imitation and identification are used. According to Hargie's study, communication skills training is taught by a wide range of tutors from behavioural sciences, acute and primary healthcare with a smaller contribution from psychologists, other professionals allied to medicine, clerics and educationalists. The training of tutors remains a worrying component with formal training ranging from three hours to one week.

The evaluation of teaching practice is only maintained formally in less than half of the respondents in the Hargie survey.

Only thirteen of the medical schools indicated a formal assessment of communication skills training. The use of the Objective Structured Clinical Examination (OSCE) has been developed over recent years and out of the thirteen schools cited eleven used OSCE as a method of assessment. Other methods of assessment include the use of video, rating scales and essays. Feedback is provided for students in terms of formative and outcome assessment techniques. These include, group discussion, direct verbal feedback, written feedback, peer and simulated patient feedback, and self identification of future learning needs.

The General Medical Council's recommendations (1993, 2002) broadly support the recognition and inclusion of formally organised communication skills training for undergraduate medical students. This should take the form of an integrated strand throughout the curriculum. Medical schools still show a significant degree of uncertainty about the time spent, content of, or evaluation methods of communication training for medical undergraduates. Plans for the future new curricula are sketchy, and a need to reduce the present diversity of programmes is not agreed as yet, some ten years on from the General Medical Councils recommendations. This means that education about communication in healthcare will remain variable depending on the medical school now and in the near future.

It is likely, as with all learning, that assessment drives learning and it is therefore important that suitable and appropriate forms of assessment are developed. This is now beginning to happen with postgraduate high stakes examinations at the Royal Colleges and the General Medical Council *(see footnote 3)*.

Learning about communication is different from much of the other learning that health professionals are exposed to because it isn't about learning a list of facts. It cannot be gleaned from a book alone. It requires more from both teachers and learners. Natelson (1990) highlights the need for medical establishments to support doctors in training and for those in training themselves to value to importance of good communication in their everyday practice.

> "Until our medical schools acknowledge the importance of good communication skills and devise a formal programme for learning these skills, it is up to you to acquire them on your own. If you ignore this issue and don't make it your business to learn the art of communication, how are you going to cope with the first patient who comes into your office with complaints that don't make any sense to you? How are you going to convince a patient to stop smoking? How are you going to tell a patient he has cancer? Doing all these things are in a days work for a doctor".
>
> (Natelson p.94 1990)

Footnote 3

For core curriculum for Senior House Officers see Collaborative Document by the Federation of Royal Colleges of Physicians – Education and Training (2003). For Royal Colleges of Surgeons see London MRCS examination. The Royal College of Surgeons (2003). For Royal College of Physicians PACES examination see Royal College of Physicians London (2001).

5.5 STRUCTURAL FACTORS THAT INFLUENCE THE PROVISION OF EFFECTIVE TEACHING

Perhaps one ought not be too surprised that the same factors and obstacles in the system arise with the teaching of communication skills as do in employing said skills in practice. Time, resources, personal will, commitments and negative attitudes are barriers cited (Hargie 1998). It may be difficult to remedy all barriers. A college can have highly motivated teachers and practitioners but little time or resources to provide the appropriate training that they themselves need in order to be good teachers in this field. One dilemma has been the need to reduce factual overload in curricula and the quest to define core and optional activities. With the ever increasing scientific knowledge and expansion of areas such as genetics it can be seen that identifying curriculum time for communication skills becomes problematic. What is left out in order to make room for this subject is likely to be a minefield rather than an exercise in time or curriculum management. Persuading unconvinced senior staff of the importance of such teaching is going to need further study, evaluation and evidence.

There are additional difficulties with the delivery of teaching. Personal vulnerability of teachers and their training needs also require time and attention. External influence from government recommendations and professional guidelines from the GMC (2002) and British Medical Association (1998) that have identified specific improvements to achieve in healthcare can help to drive institutional support at committee level.

Alternatively an experience of being a patient rather than health professional is usually a pretty sharp lesson of how important effective respectful communication is. The British Medical Journal provides streams of examples of such cases in their weekly personal view slot.

Most medical practice and education continues to include conflicting demands on health professionals. The time needed for effective learning, reflection and the development of patient-centred practice is scarce. There is some evidence that courses in communication skills in themselves will change behaviour in the long term, (Maguire 1986, Bowman 1992). But cautious acceptance of such evidence should be called for. Other organisational issues are also influential. To offer someone training and then expect them to go back to a clinical environment which all but refuses to acknowledge the need to change practice institutes an unpleasant double bind. It may be argued that to offer insight through education and to then disallow practice is harmful to the learner. She knows what is good practice but is unable to carry it out. Institutional issues, such as staff development and training, competing with the need to provide direct patient care in already over stretched clinical environments are not insubstantial. The conscientious have to grapple with this reality everyday and are left apologising for a situation over which they have little control. Colleges and hospitals are not good at providing counselling or support for students and practitioners, unlike most other universities or companies in the private sector (Banks 1989). This is despite recommendations even as far back as 1972, when the Briggs Report recommended that, for example, nurses ought to have regular access to a counsellor.

Having described the current situation of teaching and learning about communication in healthcare as varied with regard to curriculum design and delivery and learner need satisfaction there remains the additional problem of recognition of the fundamental importance of the satisfaction of the basic human needs for autonomy and communication.

5.6 WHERE IS AUTONOMY IN THE SCHEME OF COMMUNICATION TEACHING?

What we have unearthed is an overall picture of patchy communication teaching. It is patchy on all counts. Dickson, Hargie and Morrow, and Kurtz and Silverman have offered examples of structure and process, content and outcome. Teaching methods have been outlined. Learning about communication in healthcare must inform us about more than simply learning a set of techniques or skills - the point has been made that learning communication skills in a theoretical vacuum is not a good thing. It has already been made clear in chapter one that effective communication has a positive effect on patient outcomes. The types of skills that are helpful in ensuring effective health professional/patient communication are commonly taught throughout most educational programmes. They are taught because patient satisfaction has been shown to be increased, patients get better quicker and they are more likely to adhere to advice and treatment. These are the ends in themselves as described in the literature. What has not been adequately covered is the role of autonomy, and how employing these skills will effect autonomy. It has been argued in chapter two that human autonomy is a basic

need. It is also considered so in terms of medical ethics. How can individuals make an informed choice about healthcare without effective communication?

> "Many bioethicists regard respect for autonomy as a central principle in determining how doctors should act both in medical practice and in clinical research. Informed consent is regarded as perhaps the most important concept flowing from the primacy of the doctrine of autonomy".
> (Little 1995 p.122)

But in communication training, we find that references to 'autonomy' are virtually non-existent. Implicitly there are messages about locus of control, and allowing the patient time and space to either give their view or to assimilate information (Kurtz et al. 1998). But the reason for these activities is not set in the context of protecting or increasing autonomy and does not refer adequately to the concept of patient concordance.

5.6.1 Concordance

The term 'patient-centred' is much quoted recently. What does this mean and what concepts support such an approach? The benefits of effective communication and patient-centred approaches may include increased concordance in the consultation and health professional and patient interactions. Uptake of treatment by patients may be increased and life will be easier for the health professional, but this ought not to be the over-riding concern. If it is, then there is the danger of falling into the ethical quagmire of vested interests and the danger of influencing behaviour for the wrong ends; namely reducing a patient's autonomy for the ends of the health professional. Even if done with the best possible intention of considering what is best for the patient, it is not enough.

Concordance may not necessarily result in changed patient behaviour. The aim is to bring differences into the open for discussion. The health professional and the patient may agree to disagree in the end. The concept of concordance is especially linked with prescribing and taking medicines. The following definition is helpful to clarify the term:

> "Concordance is a new approach to the prescribing and taking of medicines. I is an agreement between the patient and a healthcare professional that respects the beliefs and wishes of the patient in determining whether, when and how medicine are to be taken. Although reciprocal, this is an alliance in which the healthcare professionals recognise the primacy of the patient's decisions about taking the recommended medications".
>
> (www.concordance.org)

Britten (2003) states that few of the studies of communication about medicines explore or examine the differences in health professional/patients perspectives, perhaps, she notes, because this is rarely addressed in practice (Britten et al. 2001).

5.6.2 Patient participation in the wider context

Health professionals should morally and legally pursue patient participation in healthcare choices. This will be so even if the patient ultimately defers to the health professional, because in light of their belief and trust in the health professional's expertise and knowledge. Judging how far to go in any situation requires an ability to take the cues from the patient. On the one hand, patients ought not to be robbed of the freedom of informed choice, but on the other, they ought not to be badgered into having to make a choice that they do not wish to make. The notion that a health professional simply cannot make a decision *for* a competent patient when the patient's values differ

significantly from her own should become a truism of professionalism within healthcare. Such differences in values can only be discovered and addressed sensitively through effective communication practices. Wear (1993) gives the following examples to illustrate the above point; elective termination of pregnancy, management of late stage cancer and choices between renal dialysis or transplant (Wear 1993 p.59). He states in summary:

> "Theoretically there is always a choice, often this choice is a significant one, and the physician should at least identify the choice to the patient, if not insist that he grapple with it."
>
> (Wear 1993 p.60)

It has been comprehensively argued throughout this thesis that paternalism loses out against collaborative decision making when it comes to respecting patient autonomy. Doyal and Gough's theory of human need (1991) has provided the firm theoretic argument for this. Paternalism loses out not because all paternalists are arrogant or authoritarian but because paternalism routinely excludes patients from the process of participating in decision making in any meaningful way, thereby reducing patient autonomy. This position is supported by others (Wear 1993 p. 25).

So if sets of skills are learnt which, can at least, be used potentially as instruments of influence (including paternalistic) then we must ensure an ethical framework supports these skills, to reduce misuse. During communication training students will learn a number of techniques which can be used to influence patients and colleagues. In order to avoid distorted communication and a focus on strategic action as described by

Habermas there must be honest, transparent and explicitly stated goals for communication. Habermas has provided a framework for the structure and process of communicative action that is most helpful in this regard.

The overall aim for communication in healthcare ought to be the protection, maintenance and enhancement of individual health and autonomy and the avoidance of harm. If these aims are met then health professionals can claim to practice patient-centred approaches to their interviews. Individual health professionals need strategies for effective communication to enable them to help patients to make collaborative decisions with regard to their health needs. The intentionality then for any given communicative behaviour ought to be that of trying to meet the overall goal of health and autonomy and the patient's right to communication need satisfaction through communicative action. Within this wide framework, theory and skills can be set. Being clear about the overall intention of communication is an insurance policy against setting objectives that are likely to conflict or fail to meet the overall goal. The current state of communication skills training in healthcare fails to meet the demands of providing the means to the end, that is, effective communication in practice. It also fails to make explicit the ethical nature of communication and the relationship with health and autonomy.

The need to expand our ideas about the reflexive nature of communication becomes vital given the theoretic thread of the discourse so far. To understand communication as a means of improving patient outcomes only, fails to acknowledge the primary basic

human need of communication, and the intermediate need for appropriate health professional education for this basic need to be satisfied within the delivery of medical care.

5.7 CONCLUSION

Science and technology hold a higher value in modern medicine than effective communication and psychosocial perspectives. It is time medicine, most especially medical educators, reassessed the values and priorities of the system. Biomedicine provides an intricate knowledge of the biochemistry of disease and the capacity to perform more and more sophisticated skills and procedures to deal with physiological function. What is stunning in its absence has been a structure and theory to communicate effectively with the individuals within which this 'physiological function' (or malfunction) is occurring. These changes will not be easy to achieve as learners absorb the values and attitudes of their teachers. There are examples of progress and good practice that must be built upon. It is morally unacceptable to do otherwise. Any changes must be threaded throughout the education/practice arena. Failure to do this will compound the problems rather than help. The view that communication training will not help will prevail while any training that is offered is seen as separate or perceived as less valuable than other important biotechnical facts that must be learnt. Learning about effective communication in healthcare must be integrated tightly and unavoidably with the main theoretical and clinical skills modules. Grounding in ethical

principles also needs to be taught within a curriculum and development along these lines is a positive move forward.

The difficulty raised in the eighties regarding a dichotomy between NHS teaching and college teaching remains an issue for staff development and recruitment onto teaching programmes. An integrated programme would go a good way to minimising difficulties. Joint responsibility, although sometimes difficult to manage, ought to be aimed for. Resource management will need imaginative and collaborative approaches. If the profile of communication in healthcare was raised and integrated systemically, many of the current barriers or obstacles to good communicative practice would be minimised over time. Acceptance and recognition of the position of communication skills in healthcare will only come with high quality teaching and research. It seems that selling the therapeutic benefits of effective communication is a harder job than persuading clinicians to use highly toxic medications or introducing more invasive procedures.

For communication skills training to be effective it is important to take on board the advantages and disadvantages of different approaches. The 'thinking - feeling - doing' model is simple and may be useful in helping to recognise gaps and is easy to master conceptually. It may well be an appropriate starting point for basic level learning. There is also a need to take very seriously the emotional and mental health of health professionals and include this perspective in teaching programmes. The thing is where do we go from here?

The next chapter will describe a proposed strategic approach to teaching communication which takes on board the advantages and minimises the disadvantages of recognised methods and models of teaching and learning. The proposed strategy will aim to meet communication, health and autonomy basic need satisfaction as the fundamental requirements of effective communication in healthcare. The satisfaction of these basic needs has been largely unrecognised and unattended to in clinical communication teaching. Certainly the recognition of communication as a basic human need as argued in the terms described by expanding Doyal and Gough's human need theory explains why this has been so. The reflexive nature of the basic needs of communication and autonomy and the intermediate need of healthcare will be further illustrated. The institutional and systemic influences in health professional education and practice, which are likely to maximise patient involvement in medical decision making and how we can aim to meet, at least in part the demands of Habermas' theory of communication will be considered.

CHAPTER SIX

A COMMUNICATION CURRICULUM IN HEALTHCARE - A STRATEGIC APPROACH

Chapter one described the multifactorial nature of problems of communication in healthcare. Any strategy therefore that is designed to deal with such problems will in itself need to be multi-dimensional. Chapter four explored consent procedures and the Kennedy Report as an example of a systemic way forward for the collective responsibility of government and professional bodies in addressing patients' and relatives' communication needs in healthcare. A major component of any strategy will be an educational one. Indeed the preceding chapter outlined historic and current approaches in healthcare education programmes and discussed reasons why they were failing in some regards.

In her book The Autonomous Patient, Angela Coulter (2003) stresses the continuing need for training programmes for health professionals to help them cope with patients who may want to be treated as equal partners in the doctor/patient relationship. The evidence that patients require information, want to be listened to and need help to weigh up risk factors in shared decision making is compelling so far. Investment is needed in programmes that include communication skills to enable doctors to be more patient centred (Muir Gray 2003). In addition Muir Gray debates the need for patients

themselves to be helped in the development of communication skills, so that they can be as resourceful as they could be.

This chapter will aim to provide an example of what a communication in healthcare curriculum would look like if it were to meet the demands of basic need satisfaction of personal autonomy and communication as outlined in chapter two. In addition Habermas' theory of communication will be taken into account, particularly the notions of ideal speech, undistorted communication and the influence of vested interests and power. It has been argued that human communication is a basic human need and has a reflexive relationship with other human needs. The primacy of communication and the rational premise of effective communication systems, which allow for democratic speech rights, will be illustrated in the context of a communication in healthcare curriculum. Examples of how Habermas' principles can be embedded into a curriculum and suggestions for future development will be offered

Thus far the theoretic approaches that have been discussed inform us of *why* and *what* we need to do in order to meet basic human needs but not *how* we can do it; the pragmatic perspective of communication. The pragmatic response that embraces theory and practice is therefore a combined one. A Combined Approach to Teaching Communication in Healthcare (CATCH) will be informed by and set in an ethical framework within which the overall goals are to protect and enhance individual autonomy and communication needs. The reasons for doing so are the same as described by Doyal and Gough (1991); these are to avoid seriously harming individuals

and disabling them further than they are already through potential health problems or current ill health. Protected autonomy, together with communication needs satisfaction, means that an individual is more likely to be able to make appropriate healthcare choices which affect other life choices they will have to make in order to follow a chosen life path.

The Habermasian view requires that non-expert or lay views are taken into account in any decision making process. Moreover, a system for effective communication will allow inclusion of non-experts and democratic speech rights for experts and non-experts. The view that the health professional is the expert is based on the notions that health professionals bring codified knowledge to any patient discourse and primarily rely on that knowledge to inform decisions. Public and patient involvement in healthcare needs to include what patients actually experience, not just what patients are exposed to. Health professionals often mistakenly believe they are involving patients (Kennedy 2003). It is reasonable and right to challenge the traditional view that the doctor is the expert and there are welcome moves to do so. The notion of the 'expert patient' and that patients' have knowledge about their problems, in only the way they can, has been be argued not only in sociological terms, but in terms of ethics and law throughout this thesis through the language of rights.

> "We should not criticise nor blame professionals. Instead, we should help them through the barriers that prevent them seeing their patients as interactive partners. The place to start is at the beginning of professional education, but it is a never ending process."
>
> (Kennedy 2003)

It is important that communication goals are clear in communicational endeavours. By definition a 'strategy' implies a goal-oriented approach. The pragmatic response requires performative acts on the actors' part, in this case communicative acts to meet any intention, purpose or goal. Therefore teleological as well as pragmatic responses will be seen to be helpful in meeting communication needs in healthcare.

When considering a goal oriented approach it is also helpful to think about intention. Wittgenstein separates intentions from performative acts and goals by describing them as motivations towards a given outcome (Wittgenstein 1968). This separation is useful in the analysis of collective or individual communicative acts. For example, if the intention is to explain a medical procedure to a patient, the doctor will want them to understand (motivation) all that is involved. She will want them to choose whether to consent and if they do so, to be able to follow the treatment (goal), as it is in their best interest. Their best interest will be served by a course of recommended action, which is agreed through the inclusion of both the medical perspective and their own. However, if the doctor has explained the procedure using unclarified technical terms and has given a great deal of unrequested detail (performance/behaviour) the result may be that the patient is confused and undecided about whether to go ahead. Both may not meet their goals even though the doctor's intention was good. The situation is further complicated by, both the doctor's skills and the patient's receptive and active capacity.

The effect illness has on patients and their ability to ask questions cannot be underestimated, even when in other circumstances they would not hesitate. Even professionals' usual behaviours may change when they themselves become patients.

Merilyn Watson, an academic in medical ethics and a supporter of patients' rights and increased share of responsibility in decision making, describes how she regressed into a 'compliant' patient herself in a recent healthcare episode. Watson had a bad back and the doctor recommended a lignocaine injection (local anaesthetic) into her back, which she agreed to.

> "I wished I'd been able to say, do you mind if we just stop for a while and talk about that?' She says ' I think it's because I was undressed....when you are at your most vulnerable, its not the place to have those engaged conversations."
> (Sweet 2003)

Hence health professionals may need to take an even more active role in communicating with patients to help them achieve or maintain autonomy vis á vis healthcare decisions.

Carlos Rizo, a health professional researcher describes a similar response in a different clinical context and further reinforces the notion that the onus of effective communications has to be the responsibility of the health professional and that good communication skills and understanding are needed to deal with patient and relatives' experiences and reaction to illness and treatment.

"The health professional who catheterised me after my recent appendectomy used the anaesthetic gel simply as a lubricant, without waiting for the anaesthetic to take effect. Neither I nor my wife, who is also a doctor, openly questioned the neglect of this simple precaution, which converted an unpleasant procedure into an unnecessarily painful one. Why did we let that happen? Did we think that being passive and compliant made me a good patient? Or were we just afraid to question the authority of our care giver?"

(Jadad, Rizo and Enkin 2003)

It has been comprehensively argued throughout this thesis so far that paternalism and doctor led agendas can be problematic in even recognising and acknowledging the needs and the goals of patients, let alone meeting them. As Wittgenstein points out, we cannot 'tell' others what their intentions or their goals are, we can only 'ask' them (Wittgenstein 1968). The notion of the separation of intentions from behaviours will be returned to again in the course of this chapter.

6.1 SKILLS BASED OR THEORY BASED CURRICULUM?

A skills based curriculum in itself with no reference to theoretic underpinnings fails to recognise the potential pitfalls and dangers inherent in learning communication skills, which can profoundly affect others. Any form of communication, be it collective or individual, will have an affect on others at some level. Therefore learning communication skills alone can mean that communication skills could be used to influence individuals, possibly with little or no regard for ethical outcomes. If the argument that basic human needs of autonomy, health and communication take priority over vested interests then the imperative is for health professionals is to meet the basic human needs of autonomy, health and communication; and not to be seduced by other

professional agendas and vested interests. Health professionals have a responsibility to patients and their families to not only be competent with regard to skills employed, but also to have insight and understanding with regard to a firm theoretic foundation for their actions. Medical ethics and medical sociology provides a rich theory base to support communication behaviours in the doctor/patient relationship. Patient centredness and the need for this approach, as opposed to doctor centred paternalism is the way forward for modern doctors. A theoretic approach in itself may equip health professionals with insight and understanding with regard to communication theory, psychological and sociological perspectives and ethical recommendations, but will not ensure that they are able to actually do it in practice. Therefore the CATCH curriculum combines skills and theory. The curriculum design is heavily skills based with reference to underpinning communication theory and biomedical ethics.

Importantly CATCH is also combined in as much as it ought to be integrated into a mainstream health professional curriculum. Effective communication will not be framed as something that health professionals do when they have dealt with all the other tasks and problems that patients present. Communication is central to medical practice and needs to be taught as such.

6.2 MANAGING THE THEORETIC COMPONENT

Theoretic underpinnings for communication curricula are important, it needs to be made clear that it is what health professionals actually do which is important to patients.

Therefore, most of curriculum teacher/learner contact time needs to be focused on communication skills based activities. Structured skills based learning is in keeping with other curricula in medical schools across the country and North America (Kurtz 1989, Simpson 1991, Seely et al 1995, Kurtz and Silverman 1998). What other curricula do not make clear is what theoretic components are used in their teaching, and to what extent. Kurtz and Silverman (1998) give examples of research based evidence of communication skills content used in their teaching and this is no doubt an important part of a curriculum. Communication skills should be subject to the same demands for evidence based practice as any other clinical activity. However, notions of basic human need have not been developed and represented in the current research base.

The research base provides the evidence that if clinical communication skills are improved then patient satisfaction and understanding is also increased. But what is it that is important about increasing patient satisfaction or patient understanding? It is surely not because it increases patient adherence alone. What is it that health professionals need to learn in relation to satisfaction and understanding? CATCH makes meeting the overall aims of basic communication and personal autonomy need satisfaction the core purpose of effective communication in healthcare. Patient oriented communication and understanding in healthcare ought to be aimed for, and the onus is on health professionals to lead this.

6.3 MEETING COLLECTIVE AND INDIVIDUAL BASIC AUTONOMY AND COMMUNICATION NEEDS

Despite the notion that Habermas' lifeworld and the communicative actions within it are not unproblematic in themselves (especially in relation to power and control). It is out of this social and cultural collective action that the rationality of individual communication is potentially optimised through the expression of communicative competence within ideal speech situations (White 1988 p.99). Moreover, given the thread of theoretic argument in this thesis it is clear that the liberational goals of rational communication are worth fighting for and can be achieved through communicative action. Habermas argues that society's claims for performative action (speech) are valid. Central to the argument is the acceptance that processes of understanding, interpretation, moral expectation and expression mediate them. Thereby this encourages and supports 'good societal life' and it is rational to facilitate such action. Communicative action can be understood as the process by which development and evolution of the lifeworld occurs *(see footnote 1).*

In addition to Habermas' ideas, sociological models and analysis of the doctor/patient relationship *(discussed in chapter 1, pages 57-62)* highlighted some of the negative effects that the domination of medical and scientific knowledge have had on culturally reproduced knowledge and beliefs. It therefore follows logically that the systems

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footnote 1

For further discussion re: Habermas' interpretation of modernity and rationalisation, see Stephen K White (1988) The recent works of Jurgen Habermas: Reason, justice and modernity. Chap 5 pp 90 – 123. Cambridge University Press.

world, in this case healthcare, and medicine specifically, having colonised the lifeworld to varying degrees ought to, through communicative action, support communications which challenge systems power bases and vested interests that threaten to undermine the reproduction and strengthening of a rationalised lifeworld. The continuation of 'valid knowledge,' – that is, knowledge gained through communicative action in as close to ideal speech environments as is possible or practical – requires communicative action by the systems world to validate lifeworld symbolic reproduction. In other words health professionals with codified knowledge ought to listen and act in other ways that respect and acknowledge lay peoples concerns ideas and expectations.

Doyal and Gough have been helpful in this regard. In their theory of human need they provide objective and universal culturally transmitted human needs which can help welfare administrations to take into account the lifeworld. The conceptual notion that personal autonomy is a basic human need that requires satisfaction in order to follow ones life path and defined in such terms provide a compelling theoretic model. Healthcare providers and medicine itself has reached a strong consensual agreement that the protection and validation of personal autonomy is a fundamental cornerstone in biomedical ethics.

The position is that modern society operates with a colonised lifeworld. Habermas accepts that with the extension of welfare state systems and law there is a co-dependent relationship between individuals in society and administrative systems and there is a *'pressure towards the redefinition of everyday life situations'* (Habermas 1981

translated and cited in: White 1988 p.112). This requires rational communicative action within society to ensure that freedom and well being of individuals within the lifeworld is not subjugated and that dependency on the bureaucratic experts is not expanded and developed at the expense of the symbolic reproduction of the lifeworld.

Given the complexity and difficulty in meeting all of the above it is therefore even more important that communication is defined as a basic human need, not merely understood as an intermediate need. In order for collective and individual communicative action to be valued in the same way that autonomy is, the same language of rights ought to be used.

It is within this framework that a strategic approach to teaching and learning effective communication in healthcare can be developed. To this end it is not behaviours alone that are the concern, even though individual competencies have been agreed to be important in everyday medical care. What has been proposed in this thesis is a theory of communication need satisfaction. Communication need satisfaction in healthcare can be aimed for through a strategically organised healthcare professional education programme that takes into account fundamental ethical thinking and which will apply these principles both conceptually and behaviourally.

The integrated approach that CATCH demands means that the moral and medical ethical teaching of consent, truth telling, autonomy, and core communication skills are delivered in joint courses for some learning and that separate learning sessions in

communication and ethics refer to each other as appropriate throughout the curriculum. (*See appendix 2, page 335* for an example of a joint communication and ethics course for health professionals in early training). This helps to make the co-dependant relationship that each have on the other explicit. Doyal and Gough's argument of universal objective human needs being the same for everyone everywhere can be supported in the communication teaching. The medical ethics teaching can support the notion that it is not good enough to simply know these principles in your head. It is the application of these principles through effective communication that counts. We decide whether or not someone is an ethical practitioner by the way they behave. Communication behaviour is the most prominent behaviour in every day practice that will lead us to make judgements on health professionals' ethical stance. Effective communication in healthcare ought to be maximised in order for patients to make informed choices about their healthcare and to minimise serious harm caused by health problems as patients experience them, not as health professionals define them. Serious harm caused by reducing patient autonomy and the failure to meet basic communication needs are avoided. In doing this, hopefully, patient understanding is also increased and they are more likely to be satisfied as a result. But the main aim is not that of patient satisfaction, this is an objective, a useful outcome measure for health professionals and healthcare managers when evaluating services. The main aim is to meet basic needs.

The theoretic base on which to build a communication curriculum has been described in chapters two and three. Linking notions of autonomy, truth telling, consent and confidentiality with practical communication skills safeguards against the risk of skills

taught in a vacuum, merely to manipulate patients for ends other than their best interests. The following points should be taken into account in curriculum content:

- The nature of the doctor/patient relationship ought to be discussed from the sociological perspective as well as using the ethical and professional bodies and statutory recommendations.

- Patients' health beliefs and psychological responses to health and illness are important and ought to be linked to communication skills sessions.

- The opportunity to highlight and raise learners' awareness of the dangers of distorted communication, as described by Habermas, will provide a rational argument for the ideas and application of these ideas and recommendations.

- Clinical communication is a core clinical skill.

All of the above can be considered from the collective and societal perspectives. The pragmatic part of this approach comes from carefully constructed small group and individual communication skills practice based sessions.

6.4 CURRICULUM DESIGN

Kurtz and Silverman (1998) describe their curriculum as a helically structured framework based on Dance's model of communication. That is to say that subject matter is introduced, reiterated, reinforced and returned to again at a slightly different level each time. Research evidence is referred to opportunistically in sessions.

What follows is a description of the CATCH strategic approach and this is separated into four sections that will be briefly outlined: links with other disciplines, tutor communications and attitudes, further integration and curriculum design.

- Links with other disciplines

Where CATCH differs is that the educational activities organised and delivered in order to help meet the demands of effective communication in healthcare are grounded in human need and communication theory. The links with other disciplines and their theoretic bases is made transparent and explicitly to learners, and the linked teaching is contemporaneous.

- Tutors communications and attitudes

This requires positive and open communications between subject tutors to ensure a harmonious approach. This approach models good practice, respectful and positive attitudes towards others, contribution to outcomes and parallels effective teamwork in the clinical setting. If teachers model effective behaviour then learners are at least enveloped in attitudes and behaviours that support the notions, concepts and behaviours

that are taught in the communication curriculum. The teacher/learner relationship will mirror the doctor/patient relationship.

- Further integration

Essentially theory is linked to practice and clinical experience. Clinical and professional communication skills can be introduced at the stage that matches other learning. For example, if learners are covering health beliefs or lay perceptions of illness in psychology and sociology, then it would be appropriate to integrate the communication skills needed to explore patients' concerns, ideas and expectations at the same time in the curriculum. In addition, tutors teaching on the sociology and psychology courses are well placed to facilitate communication skills sessions (with training if appropriate). This can be further integrated by ensuring the sessions support any patient contact in clinical areas that learners are exposed to. What is then presented is a theory component, a practise component and clinical exposure. This model runs throughout the whole curriculum. Content and context will differ and become increasingly complex and challenging as the learner progresses.

- Curriculum design

CATCH is also based on helical learning and is spiral in design. The spiral curriculum was first introduced by Jerome Bruner (1973) and is similar in approach to Dance's model (1967). A definition of a spiral curriculum is:

> "Learning planned in such a way that a pupil encounters concepts at a number of stages. Concrete before abstract, simple before complex, easy before difficult."
> (Dictionary of Education p.67 1993)

A spiral curriculum allows for learning to develop in a logical manner with reinforcement of previously learned knowledge, skills and attitudes, along with new material. The intention of the originator Bruner, was that an important concept should not be something to be learned on a single occasion and then taken for granted 'as learnt', but that concepts need to be encountered in a variety of contexts over a period of time and gradually assimilated.

This approach is particularly pertinent to skills based clinical communication sessions. Communication, like other skills needs to be practised in order to reach appropriate levels of competence. Levels of competence will increase with the stage of the learner and their clinical experience. Likewise the contexts for practising skills will become more complex as the learner proceeds through the curriculum. Longitudinal, integrated programmes have been shown to give the best results. Optimal training of communication skills in a medical curriculum is argued to be achieved through regular and consistent sessions that are integrated into the whole curriculum (Van Dalen et al 2001).

The concept of integration is that any communication curricula learning supports, and is supported by other theoretic, clinical skill and patient management learning. This means that the communication curriculum will run from the beginning all the way through undergraduate medical training (or other health professional training) and continue through postgraduate clinical education. Regular and consistent learning sessions are

timetabled. Each session consists of a skills based practice component and directed research based reading or academic references and articles.

6.5 SKILLS COMPONENT – CONTENT OF A CORE CURRICULUM

CATCH defines and incorporates the core communication skills in undergraduate education for health professionals, over which there is increasing agreement across medical schools. These are the skills needed to carry out the clinical communication tasks a health professional needs to be competent in. A national conference at The Royal Society of Medicine (Royal Society of Medicine 1999) resulted in the first stage of agreement for the skills content of a national core curriculum for Communication Skills across UK medical schools. This reflected an emerging consensus of the role of effective communication in healthcare, especially with regard to doctor/patient communication. A consultative document was produced for dissemination and debate.

CATCH content, curriculum design and other work being developed along with this thesis was presented at the conference as an example of a longitudinal integrated communication in healthcare curriculum. CATCH includes the core communication skills that have been agreed to contribute to a core curriculum for undergraduate health professional education.

CATCH includes a guide within which core skills are nested and offers a framework within which health professionals can develop their own personal styles and skills for

consulting with patients and relatives. The notion of the guide is not to be a prescriptive checklist that is followed in a linear fashion, but a core document that learners and assessors can check communication behaviours against. It is used to inform learning objectives and assessment criteria. The next section will provide a brief overview of current medical interview skills guides and the rationale behind the development of the CATCH guide.

6.6 A GENERIC PATIENT CENTRED INTERVIEW SKILLS GUIDE

Medical Interview guides have been developed by others. Three well documented guides are; the three function model (Bird and Cohen 1991, SEGUE (Makoul 2001), The Calgary-Cambridge Guide (Kurtz and Silverman 1998). The three-function model discusses the three main functions in a medical interview according to the authors. These are patient management, relationship, and education. SEGUE provides more of a checklist approach. The Cambridge – Calgary Guide includes over seventy criteria allocated to certain stages of the interview.

The patient centred guide developed in CATCH provides a document that can be used as a working tool by learners and teachers. Learning objectives and assessment criteria can be taken directly from the guide, which makes learning and assessment transparent for students. Therefore there are only fifteen key criteria in the guide and it is divided into three sections:

- Opening and establishing rapport
- Exploration, managing time, content and conveying empathy
- Closing

As the guide is just a framework within which to work, health professionals need to take responsibility for developing and interpreting which skills would be most useful for different purposes. Learning the criteria by rote or in order of presentation in the guide will not mean that learners are able to carry out the skills in practice. But skills needed to cover the key criteria can be argued to be generic and universal, in as much as some aspect of them will be needed in almost any type of medical interview. They are needed to protect and enhance individual autonomy, to acknowledge and validate the patient's perspective, to meet their basic human need for effective communication and to work towards health professional/patient consensus.

The guide is content free and is essentially a guide for interview structure and process. Each key point has examples of communication skills which would help to fulfil the aim of effective application of the point in practice. It should be noted however, that some skills will be employed at more that one stage or point in the interview; anticipating and demonstrating empathic responses, for example. Explicit in patient centred communication learning is that health professionals learn to read cues and anticipate their patients' communication and information needs, wherever and whenever they present themselves *(see footnote 1 and appendix 3, page 416 for the guide).*

6.7 COMMUNICATION SKILLS AND CLINICAL TASKS – INTRODUCING INCREASING COMPLEXITY

It is useful to differentiate between communication skills and clinical tasks. By de-coupling skills and tasks it is possible to be clear about what skills to focus on and how they may be employed in a range of clinical scenarios, tasks in practice sessions and clinical settings. Core communication skills advocated in CATCH at a basic level include:

Figure 6.a Core communication skills

Listening
Developing rapport
Question styles
Reflecting and clarifying
Demonstrating empathy
Checking for understanding
Summarising
Working with feedback

footnote 1

A sister guide 'Patient centred breaking bad news guide' drawing on recent and current literature has also been designed to use in conjunction with the generic guide (see appendix3). It is envisaged that as CATCH develops further other communication oriented clinical tasks guides will be developed and designed to maintain a consistent and recognisable format for clinicians, tutors and learners. An explaining guide and a negotiating guide would be two such examples. These guides provide more detailed and focused key points for health professionals to include in their patients' interests.

Each of the above skills will be broken down to component parts and micro skill level. For example; effective listening will include the use of eye contact, posture and appropriate facial expression, the use of a range of question styles, para-linguistic encouragers such as hmm, aah and others. It is important to include non-verbal and verbal skills as effective communication will be built up and understood as a multi-levelled concept. The non-verbal communication which accompanies verbal communication is extremely powerful and influential in the communication of meaning and is culturally learnt (Argyle 1988). For example: If I ask you how you are in a rushed manner, do not establish eye contact with you, turn away or am preoccupied with another interest then you are hardly likely to believe I am really interested in how you are. However if I maintain eye contact with you, have my body turned towards you, am not distracted by other interests and listen to your response then you will feel that I am attentive and interested in you. This does not necessarily take more time but the time is used more effectively in relation to the communication process and outcome. In the doctor/patient relationship this is an important influence in the development of a positive doctor/patient relationship.

Core communication skills are needed to carry out core basic clinical communication tasks:

Figure 6.b Core communication tasks

Exploring
Explaining
Negotiating (involving patients in management decisions)

The entire above are then incorporated and contextualised into medical practice in higher order clinical communication tasks, some of which are listed below (this is not an exhaustive list). (GMC 1998, 2001 and Royal College of Physicians 2003) have published authoritative documents outlining communication skills, which further reinforce the need for acknowledgement of the importance of core communication skills in medical practice.

The flow diagram *(figure 6.c on page 274)* demonstrates how core communication skills feed into clinical tasks and contexts. Contexts will include working with different patient groups who will have individual and specific communication needs in a variety of clinical settings. This further reinforces the notion that skills cannot be learnt in a rote or prescriptive fashion, as health professionals need to be aware of patients' communication needs as they arise. (Patients tend not to behave in a text book fashion.)

6.8 AN EXAMPLE OF DE-COUPLING SKILLS FROM TASKS

Let us take an example of a core communication skill, in this instance reflecting and clarifying, and break this down into micro skills in order to understand how the skill might influence a communication process. The task in this instance is exploring a patient's problem with a view to diagnosis and the formulation of a management plan for negotiation. Reflecting and clarifying is particularly helpful in the exploring phase of an interview.

Reflecting and clarifying

The humanistic psychologist Carl Rogers (1951) originated the use of reflection as an interview skill. Rogers developed a non-directive counselling model whereby the counsellor took a facilitative approach, encouraging the client to explore, talk about and where possible come to their own conclusions for problem resolution.

The reasons for reflecting communications back to patients are to: acknowledge and validate concerns; check for meaning and understanding; to give the patient the message that s/he has been listened to; and to facilitate further disclosure. This is an important skill with regard to reaching consensus and shared decision making, as argued in theoretic terms by Doyal and Gough, Habermas and others in chapters two to four. The onus is on the doctor, or other health professional, if appropriate, to establish what the patient means by their statements, and what underlying concerns they may have in relation to presented problems. The patient's non-verbal communication is also going to add meaning to verbal statements. By paraphrasing what the patient says and how the doctor interprets what the patient has said, the doctor will give the message that she has listened, tried to understand and is willing to check out her understanding. This will also encourage the patient to continue telling his or her story. But this process ought not to stop there. It is equally important to check that the interpretation of understanding matches the patient's own intentions and meaning. This way there is an opportunity for the doctor to begin to get a sense of the patient's own beliefs, concerns and expectations regarding their problem and explore further.

Reflecting and clarifying are skills that are useful in core clinical tasks, such as exploring patients' problems, the medical history taking component of a medical interview, explaining procedures and checking for patient understanding, gaining informed consent and checking for patient understanding. Reflection can involve reflecting factual content, emotional content or both aspects of communication.

Dickson, Hargie and Morrow (1989) offer a useful five-step model for reflection:

1) Recalling and restating the speakers message correctly;

2) Identifying the main factual and/or feeling aspects being expressed;

3) Translating these factual and/or feeling components into one's own words;

4) Verbally reflecting the essence of these facts and/or feelings;

5) Monitoring the reaction of the other person, to judge the accuracy of the reflection.

Take for example a simple scenario. Mr X has had lower back pain for two weeks. He has been taking over the counter analgesia but his back is not improving. He has not been able to do any gardening for this period and gardening is one of his major hobbies. He describes the nature of the back pain to his doctor. The doctor's task is to explore Mr X's health problem and concerns.

Clinical task: Exploring a patient's health problem

Communication skill: Reflecting and clarifying

Clinical context: General practice

Dr: Can you describe the pain to me Mr X? (open question)

Pt: Yes it is constant, but more painful when I twist or bend down. Then it becomes more severe, sharp twinges.

Dr: Sharp twinges? (echoing/paraphrasing)

Pt: Yes, almost stabbing. I'm scared to move then.

Dr: You are scared to move? (paraphrasing and opening to empathic response)

Pt: Yes. I am scared I will make it worse.

Dr: OK. That makes things difficult for you (empathic response). Let's have a look. Can you point to the pain precisely? (closed question)

Pt: Yes, it is just here. (patient indicates lower lumbar region of his back)

Dr: Right, So the pain is constant but worse on movement and it is concentrated on your lower back. Have I got that right Mr. X? (clarifying)

Pt: Yes.

Dr: How is this affecting your everyday life? (open question)

Pt: Well, I have a lovely garden and it is my main hobby. I have a lot of plants ready to go in at the moment and I just can't do much gardening at all. All my work on the plants will be wasted if I can't do something in the next few days. I am hoping you can sort me out quickly. (accompanied by anxious expression and pleading tone)

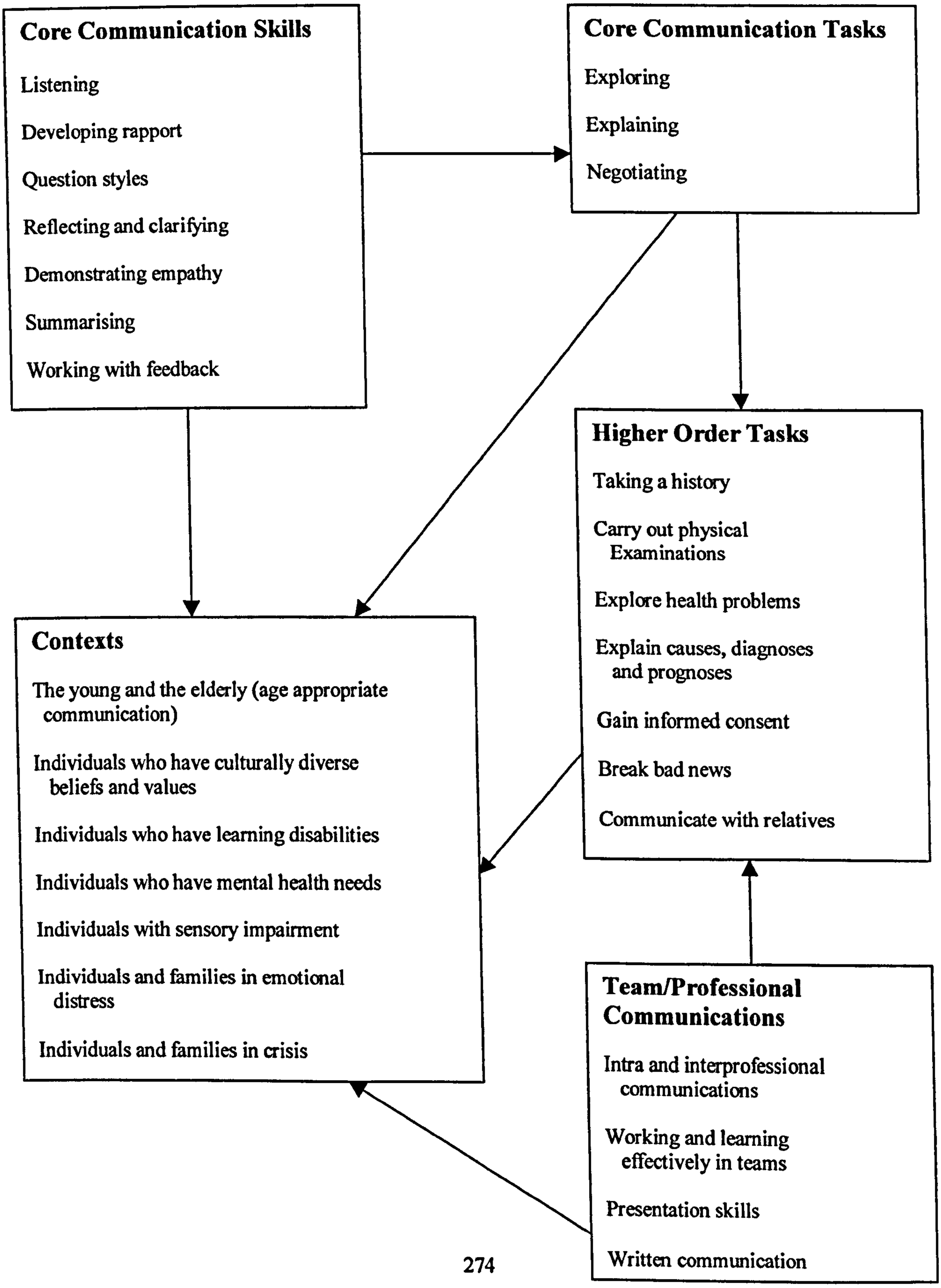
Dr: So you are anxious to get on the move again so you can get back to your garden? (clarifying affect on daily life and insight into patient expectations.)

Reflecting and clarifying includes a range of micro skills:

Different question styles, attentive listening, non-verbal encouragers, such as nodding, facial expression and paralinguistic communications to convey empathy, paraphrasing, mini summaries and using the patient's own words when reflecting back verbally.

It is possible to take any of the core communication skills and use the same approach to construct and deconstruct clinical communications and tasks. In this way we can begin to understand the multi-levelled complexity of even seemingly simple communications. The reflecting and clarifying example shows how communication skills interweave with each other. The predominant skill under focus does not stand alone in interactions. Communication is always multi-dimensional. The focus skill in the above example, reflecting and clarifying, requires other skills such as maintaining rapport and developing and demonstrating empathic responses, as these help to define the nature and meaning of the communication. If the health professional is skilled in using these skills then they can be more assured that the patient experiences the communication as personal to them and about them.

Figure 6.c Flow diagram of communication skills, tasks and contexts



6.9 TEAMWORK COMMUNICATION SKILLS

Although this thesis concentrates on patient oriented communication needs, it should also be stated that communication curricula should include professional communications that require effective communication skills often in very much the same way as communication skills are used in patient interactions. Essentially core communication skills are transferable to all aspects of health professional life. The GMC in 'Principles and Practice' identifies interprofessional communication competence as a key domain in healthcare (GMC 2003). It will be vital for clinical teams to be able to communicate effectively together if respect for patient autonomy and patients' communication needs are to be met.

6.10 INTEGRATION OF COMMUNICATION CURRICULUM INTO MAIN CURRICULUM - METHODOLOGY

Clinical communication scenarios are devised for students to practice specific skills in a range of clinical contexts and specialities. The main learning method for this is role-play with simulated patients. Role-play is widely accepted as an effective learning method for skills based practise (Cole et al 1995, Kurtz, Silverman and Draper 1998, van Dalen et al 2001) *(See footnote 2).*

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footnote 2

For a comprehensive account of the management of role play sessions please see Cohen-Cole, Bird and Mance (1995) Teaching with Role-play; A Structured Approach ch.34 pp. 405- 412, in The Medical Interview Lipkin, Putnam and Lazare (ed.) (1995) Springer pub.

Opportunities for practice will reflect the students' clinical attachments in the same way that earlier learning integrated communication with other social science and biomedical science knowledge. For example, when students are allocated to the emergency and accident department, then it as this point that they will have the opportunity to practice dealing with frightened or angry patients and crisis situations. When in paediatrics they will be able to practice explaining common disorders, investigations and treatments to parents and children. Notions of sharing end of life decision making processes with patients and relatives is introduced in the final year of training. Preparation for the difficult conversations they will inevitably need to have about the management of dying, afterlife care and organ donation is vital, if they are to satisfy the basic needs for autonomy and communication of patients at all stages of care.

It is also important that students are given the opportunity to reflect on their own responses and feelings when dealing with difficult communication scenarios. How do they cope? What do they do that works and what alternatives could be useful for them when their strategy for managing or coping is ineffective? What and how does the patient/relative/other health professional feedback to the learner about their communication? *(For an outline of years one to five see appendix 4, pages 420-421. For examples of session structures, learning methods and content please see appendix 5, page 422).*

6.11 TUTOR RECRUITMENT AND TRAINING

Successful integration of communication skills into a curriculum and the nature of the learning methods with small group practice and feedback will inevitably require the involvement of a large number of tutors. The approach advocated for the organisation and delivery of teaching is a 'hub and spoke' one. A department or faculty for communication in healthcare will ideally be situated under the umbrella of a division or department of medical education and linked with clinical skills. Within a communication department designated communication lecturers and administrative support will hold responsibility for the design, organisation, delivery and evaluation of the communication in healthcare curriculum. This can be argued on several points. Firstly, a department independent of any clinical speciality can work across disciplines neutrally and independently and is less likely to be influenced by internal speciality politics or vested interests. Secondly, communication skills as a subject is not viewed by the wider institution as the responsibility or specialist interest of a particular clinical group. A third and equally important point is that clinical communication in healthcare can be developed as a discipline in it's own right and evolve into a department that health professionals, groups allied to healthcare, related academics and users of healthcare can come to for advice, information and combined research interests.

The communication skills department will therefore be the hub. Health professionals and the teaching activity that is developed in clinical departments and contexts are the spokes. The communication skills department staff will offer support to clinical

departments as well as encouraging health professionals in all clinical areas to become involved with clinical communication skills teaching. This may be both in the clinical setting and in the timetabled communication department role-play sessions.

In this way healthy two-way relationships can develop between the communication department and clinical areas. The communication department can ensure that clinical areas are aware of the latest research and the developing evidence base with regard to communication in healthcare. The clinical areas can ensure that the communication department is constantly kept up to date with clinical approaches and problems and provide the department with a constant flow of material for credible and accurate clinical scenarios.

Tutor recruitment and training is a vital part of a successful curriculum. In order for integration to work in practice it is desirable to have trained health professionals from a range of clinical specialities participating in the programme. This ensures that students benefit from a wide perspective and experience and also reinforces the idea that effective communication in healthcare is highly valued by clinicians themselves. Clinicians' time is scarce; most have no space in their busy diaries and therefore there are bound to be issues around training attendance. The approach taken to support CATCH is that of establishing the minimum competence necessary to manage clinical role-play practice sessions and to work effectively using feedback with students in the clinical setting. The thinking behind this approach is to attract as many clinicians as possible to the training if commitment is not too onerous. The focus of the training is

the support and safety of learners and the development of specific facilitation skills required for role-play sessions. This is purely a pragmatic response to the problem. Medical educationalists are encouraged to participate in sessions and to observe the process as part of the school's quality assurance mechanism. *(For an example of a tutor training session structure, process and content please see appendix 5, page 422).*

6.12 PATIENT INVOLVEMENT

The very ethos of this thesis requires the voices of patients and users of healthcare are represented and heard in the delivery of healthcare. This is reflected in the design and delivery of the teaching programme. Real patients and professional role players (trained actors) form the basis of the training. All clinical scenarios are written in the patient's voice. A rolling programme for volunteer and simulated patient training is run throughout each year. The focus of these training sessions is to ensure the 'patients' have a good understanding of the needs of the students, a good understanding of communication skills themselves and are able to give effective feedback to students in practice. The real and simulated patients participate in core communication skills and effective feedback sessions as part of their training in the same way that medical students do. In this way they are familiar with the process and content that medical students have been exposed to. The thinking behind this is to aim for increased consensus about the 'what' and 'how' of effective core communication skills in doctor/patient consultations. It is also important that simulated or real patients understand that their purpose in working with students is to help them improve their

communications with patients first and foremost. So consensus about what is fed back to students and how it is conducted is vital.

Patients who have had difficult or upsetting experiences with health professionals in the past cannot use this session as an opportunity to project blame or responsibility on to the learners in the session. Therefore, training, constant monitoring and quality assurance mechanisms to monitor what occurs in practice sessions is necessary. This is not to say that sessions where volunteer patients or representatives from patients' groups are involved ought not have the opportunity to share their experiences with the students, indeed, this should be encouraged and facilitated. It is more about clarity regarding the purpose of the sessions; that is to increase mutual understanding and communication between the patients and students, not primarily as a therapy session for patients, as this could be counterproductive for both students and patients. *(For an example of the simulated patient training course please see appendix 6, page 430).*

6.13 ASSESSMENT

Health professionals are as driven by assessment as any other group and if a subject is assessed it certainly tends to add more weight to it. Ideally everyone would learn for learning's sake (and some do). However the reality is that students will cherry pick what they need to attend and what they can avoid. A range of assessment methods to cover knowledge, understanding and applied practice will be necessary. Reflective essay type accounts can encourage students to develop self-awareness and responsibility

for their own communication (Smith 1998, Burton 2002). Short answer and multi-choice questions can provide assessment of knowledge and conceptual understanding. (Verhoeven et al 1998). Objective Structured Clinical Examination (OSCE) can provide skills based assessment. OSCEs are widely used to assess clinical skills in both undergraduate and increasingly postgraduate medical education. Learners are directly observed carrying out a skills based procedure by an assessor. Objective checklists and/or global ratings provide ratings for competence and fluency in whichever skill is being assessed (Stillman and Swanson 1987, Ram et al. 1999, Humphris and Kaney 2000). Clinical communication skills OSCEs have been shown to be valid and reliable when trained simulated patients are used and standardised in terms of their behaviours (Finlay et al. 1995, Bullock et al. 1999, Colliver et al. 1999). Criteria based rating scales have been developed and are used commonly (Arthur 1999, Swartz et al. 1999 and Miller et al. 1999). It is often helpful for the simulated patients to also have a section to rate the health professional's communication as this provides patient-centred feedback about how the communication has been experienced. This is an occasion when the patients' perspective can be heard and validated and goes some way in acknowledging the need for that experience to count in objective terms. Bullock's study (1999) showed that non-expert and expert observers showed good inter-rater reliability when using structured check lists in three clinical skills procedures. Evidence such as Bullock has provided might appease or convince examiners who are concerned with validity and reliability in assessment methods to accept non-expert examiners in this context.

How Habermas would view this mode of assessment (i.e. patients rating candidates) is an interesting point to consider. The needs, objectives and assessments are still being defined by health professionals to a degree, but in CATCH the clinical communication OSCEs are patient centred in as much as simulated patients have an opportunity to help develop OSCE scenarios, through the simulated patient training programme. Bringing the lifeworld and medical world together with this degree of intersubjectivity still requires some sort of objectivity for this type of assessment to work. It is argued here that assessment for communication skills is necessary but that types and methods of assessment are in their infancy. A great deal of thought and different approaches to assessment are required if interpretive assessments that meet the demands of democratic speech and understanding are to be developed. The comprehensive development and testing of assessment methods is beyond the scope of this thesis. However, in theory, if basic human needs, as outlined and Habermas' principles of communicative action inform the teaching, then they in turn should inform the assessment. Ways forward would include the development of joint medical ethics and communication assessments regarding autonomy and consensus through communicative action. The assessment criteria would need to reflect and interpret students' communication skills in ways that make explicit the overall goals of consensus, ideal speech, patients' rights of negative freedom and the desire to reach enlightenment through effective communication. What these assessments will ultimately look like in terms of design and process are in the very early stages of thought and feasability, even compared to existing communication skills assessments. Communication competencies are behaviourally measurable and therefore useful to retain; the challenge is how to interpret behaviours and competencies

with regard to meeting the goals described. But for now clinical communication assessments are being developed using traditional assessment methods and it must be better that communication is assessed in some way regularly and consistently than not at all.

Clinical communication assessment carried out regularly in each year via a range of formative and summative methods are useful on two counts. One, the subject is valued appropriately by the institution and learners. Second, students who may be having some difficulty in communicating with patients or each other can be identified and supported before they reach qualification. Maybe then we will have a diminishing return of doctors inflicting harm, unwittingly or otherwise, on their patients and their relatives. *(For examples of assessment criteria for MBBS programme please see appendix 8, page 443).*

6.14 COURSE EVALUATION – STUDENTS' PERSPECTIVE

It is important to encourage students to feedback their views of their experience of communication in healthcare teaching and learning to the faculty and institution. This can be operationalised through a) student evaluation forms, b) student representation at committee level and c) an 'open door' policy for seeing students or groups of students. Such processes are in keeping with Habermas' rules of ideal speech, that is, communicants have the right to question and express personal attitudes, wishes and needs.

Student evaluation forms allow students to give their views anonymously. Moreover, they ought to be free from compulsion or coercion. This is helpful in the sense that students may feel more inclined to respond honestly if they cannot be identified personally, and are not being forced to comply. A combination of pre-set questions with a Likert type scale response and free text comments will allow for quantitative and qualitative analysis. Questionnaire design needs careful thought (Galloway 1997). *(For examples of student questionnaires please see appendix 8, page 443).*

Student representation at committee level and concerted efforts to ensure students' voices are heard in meetings is essential for communicative action to occur. It could be argued that there are parallels with including the patients' voice in the organisation and delivery of healthcare, with the students' voice in the organisation and delivery of their education experience in medical training.

An 'open door' policy to see students in an informal and personal way provides an opportunity for one to one, or small group discussion. Specific students' needs can be discussed more appropriately in this way. With the increasing use of e-mail as a means of communication this means that the open door can be an electronic one, thereby minimising the problems of time and geography. However, this type of communication has its limitations and does not lend itself to fluent discussion. It cannot substitute for multi-levelled face to face contact.

6.15 EMBEDDING HABERMASIAN PRINCIPLES INTO A CURRICULUM AND FURTHER DEVELOPMENT

Having described a comprehensive theoretic foundation to support communication curricula in healthcare, it may be useful to be clear about the key Habermasian principles that can be identified in a communication skills curriculum and that warrant further development than has been described thus far. CATCH will be used as an exemplar for such developments. Concern with meeting autonomy, health and communication need satisfaction remains paramount.

There are four key principles within Habermasian theory that can be applied and interpreted for communication skills teaching and learning.

- The primacy of consensus
- Communicative v strategic action
- The rules of the ideal speech situation – namely the right to participate in discourse, the right to question and to express personal attitudes, wishes and needs and the rights of negative freedom, i.e. free from compulsion or coercion.
- Enlightenment v dogmatism.

6.15.1 The primacy of consensus

Habermas argues that the main goal of communication is consensus that is rooted in mutual understanding between communicants. It would therefore seem entirely reasonable to use Habermasian theory to justify almost any communication skill

exercise on this concept alone, given this way of thinking. The very core of commonly held views in our quest to improve communication in healthcare rests on the previously described notions of patient centredness. By using Habermasian principles as the starting point it is possible to adopt any model for application in practice, as long as the model does not conflict with the basic principles. Therefore we are not forced to abandon psychological, sociological or epidemiological models of patient centredness, so long as they do not conflict with the idea that consensus is a priori. Habermas provides the moral and rational basis.

Specific sessions designed to address particular skills can benefit from a Habermasian perspective. One such example is the concept of rapport. Rapport essentially is to do with commonality, concentrating on sameness and reducing differences. When rapport is maintained there tends to be an increased sharing of ideas, concerns and expectations. These ideas are generally accepted in communication skills teaching models as the initial and vital phase of establishing a sense of trust and respect between the doctor and patient. Without successful rapport building and maintaining skills it follows that there will be a marked reduction in the likelihood of consensus being obtained through communicative action and understanding. It also follows that without rapport it becomes difficult for the doctor to inquire into the patient's lifeworld in any meaningful sense. Any attempt to bridge potential differences between them that ultimately might block the patient's uptake of care will not be identified or explored. The aim in this instance is not to imply that consensus is dependent on rapport skills alone (chapters three and four comprehensively argued the complexity of consensus) but that the

proposition is that rapport building and maintaining in consultations is part of the process.

6.15.2 Communicative action v strategic action

Informed consent was used as an example for Habermasian analysis in chapter four. When principles of informed consent are taught in communication and medical ethics curricula, either jointly or separately, the main goals of the learning are that learners understand the moral and legal imperatives for informed consent explicitly. The moral and legal imperatives rooted in rights and needs are described in the argument presented in this thesis. Reference to Habermas can be of value at this stage. If learners are able to reflect on their own communication skills and are able to develop and demonstrate communication skills that are congruent with communicative action, then in fundamental terms communication skills are being learnt and practised in order to meet basic human needs. By striving to meet the patients' needs through mutual understanding and consensus it could be argued that professional and statutory recommendations for consent procedures are justified. This is in contrast to focusing on the goal of avoiding litigation (which may indeed be a secondary motivation), which may tempt the communicant to rely on strategic action rooted in the desire to meet other externally organised goals or professional protectionism. With communicative action the rights of the patient remain paramount.

6.15.3 Ideal speech situation

In light of the two points above, at an early stage in the communication curriculum it would seem sensible to present the ideal speech situation to learners to provide the ethical communication foundation on which to build their communication skills. The notions that all communicants have the right to participate in any discourse, question, suggest and express themselves; ought not to be prevented or pressurised into participating; and have equal validity rights, are the fundamental principles of the Habermasian position. It seems entirely plausible and possible that common learning methods in communication skills curriculum can accommodate this. A well-designed helical curriculum such as CATCH is based on sound principles first and foremost and not driven by content alone. This is indeed an advantage as it allows flexibility. Sessions covering exploring, explaining and negotiation skills would provide the opportunity to practice the aims of ideal speech situations in behaviourally stated terms. As skills are revisited and built on as learners become more proficient in communication skills and clinical knowledge, there is ample opportunity to develop skills to meet the demands of Habermas' ideal speech rules using simple or complex scenarios.

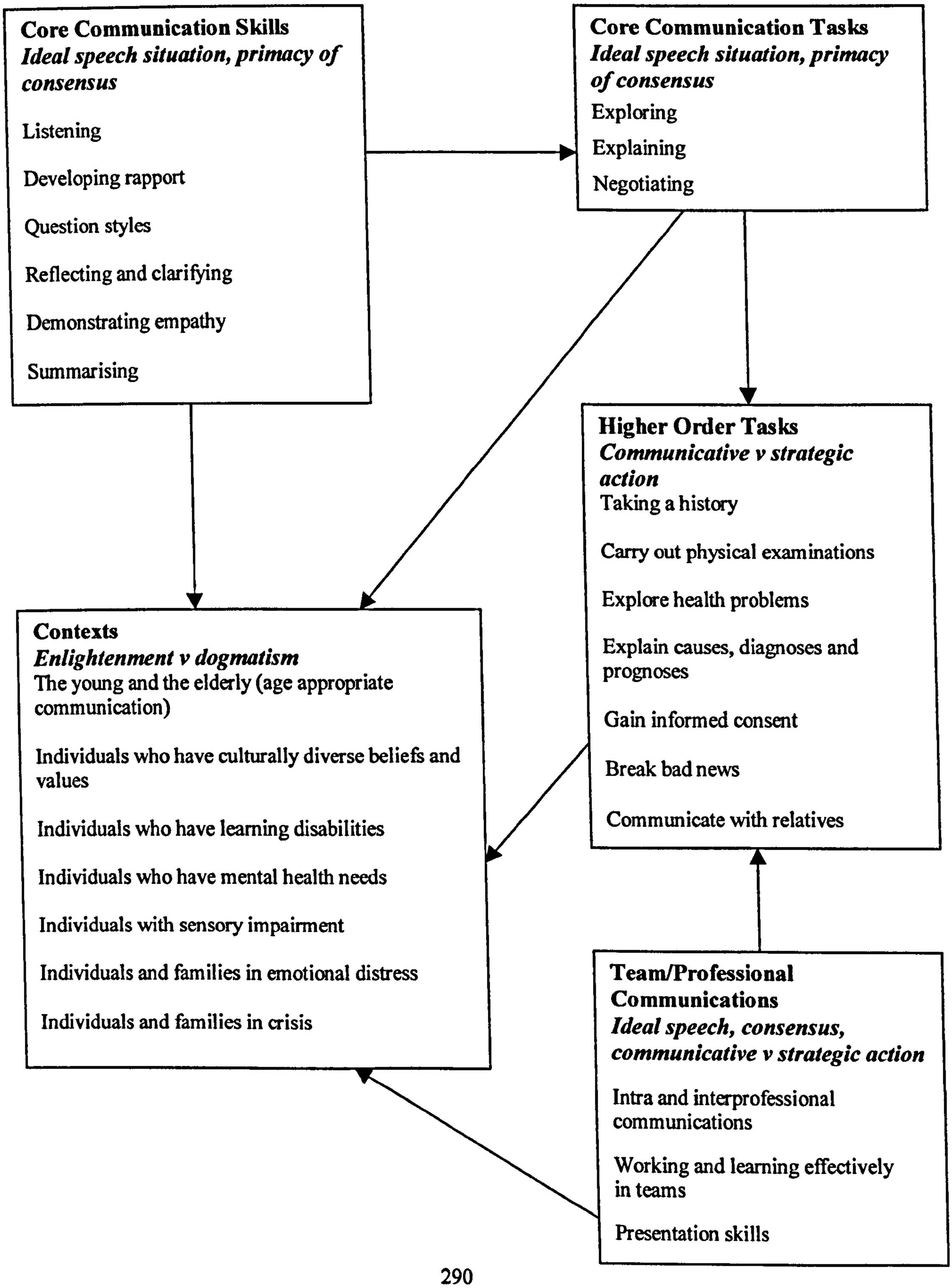
6.15.4 Enlightenment v dogmatism

Habermas clearly argues that enlightenment is superior to dogmatism. It is essential that patients are not pressurised or deceived in communicative acts, therefore, it follows that doctors have a responsibility to enlighten; that is, to explain treatment options and

health promotion and to be enlightened themselves. This involves working with patients' own beliefs and values, to listen and be listened to. The principle of enlightenment can be referred to in sessions when considering language and checking for understanding in doctor/patient consultations. The doctor has a responsibility to share her codified knowledge with the patient in language that is understood. The avoidance of unexplained technical terms and medical jargon is one aspect of the principle of enlightenment. The other is in relation to dogmatism. At this juncture it would be helpful to link the ethical position of respect for persons autonomy and cultural beliefs to the increasingly unacceptable authoritarian or paternalistic approaches with patients. If in educational sessions learners are encouraged to think critically about their own beliefs and values, as well as the scientific knowledge base they will inevitably have, then the hypothesis is that they are in a better position to question and reflect on how they respond to that knowledge themselves. One would hope therefore that learners would be more able to frame their communications in ways that are educationally and emotionally supportive for patients. In this way patients are aided through enlightenment rather than dogmatism to make decisions which they believe are right for them.

The following figure 6d (p.291) provides a brief overview of how Habermas might be explicitly linked and incorporated into curriculum sessions.

Figure 6.d Flow diagram of communication skills, tasks and contexts incorporating key Habermasian principles



An initial introduction given in the form of a lecture can outline the four key principles that provide the theoretic ethical communication framework for effective communication in healthcare. In an integrated curriculum this will be delivered at the beginning of the medical course. Medical students have not come to medical school to study philosophy, so it is unreasonable to expect them to read through large chunks of Habermas' theory. However, a brief outline, with additional reading for learners who are interested or motivated can be given.

Following the introduction, the four key Habermasian principles that inform ethical communication practice best designed to meet basic human needs in healthcare can be focused on in group sessions. Figure 6d illustrates how the four principles can be linked to core communication skills and tasks. It is however important to bear in mind the curriculum design of CATCH. The curriculum is a helical curriculum that insists knowledge, skills and attitudes are revisited and built upon. Therefore it is not simply a case of covering primacy of consensus, for example, in one session and not referring to it again in another because the main focus of that particular session is communicative v strategic action. These concepts become heavily dependent on each other as the learners become more skilled and clinical scenarios become more challenging. This is the same principle upheld in any skills based communication learning. For example, because establishing rapport is covered in early sessions when focusing on exploring patients' concerns, it does not mean that it is not revisited in later sessions, such as explaining a procedure or breaking bad news.

Having laid out a structure for addressing the key principles it would be sensible to bear in mind opportunistic learning and working with the queries and concerns that learners generate. Therefore, if it seems appropriate to cover aspects of a principle other than the designated one in a session then it would normally be fine to do so, as long as the agreed learning objectives could still be met.

One innovative development of CATCH that embodies Habermasian ideas of discoursive democracy is the expansion and development of the roles that patients themselves can have in medical education. Moreover, by increasing patient input into medical education it is proposed that bridges can be built in an attempt to deal with the difficulties of arbitrary division of lifeworld. Simulated and standardised patients are used to good effect and this is in keeping with other medical curricula. It has already been noted that patients can be regarded as experts in their own right (Tuckett et al. 1985). However the intention is to go a step further in this regard. Currently plans are well underway to establish the programme outlined next.

Volunteer patients and role players will be invited to participate in the teaching programme. They will not be asked to portray specific characteristics or simulate a particular health problem in the first instance. They will be will be trained to work directly with medical students in clinical and communication skills teaching and learning. This is an underdeveloped field, although there are ad hoc examples of small projects in the UK there is little published data to date that relates specifically to the teaching and learning of physical examination and communication skills through

working directly with patients as teachers (Wykurtz and Kelly 2002). Work has been carried out in the USA in this regard for a number of years (Stillman et al. 1983, 1990), but the development there has been mainly with professional role players (Colliver JA, Swartz MH. 1997, New York Times 2001).

It is proposed that a patient will be a patient educator. The core skills for focus initially will be physical examination of chest, cardiovascular system, abdomen, neurology and ear nose and throat and communication skills. As well as bringing their own ideas views and experiences of healthcare, the patient will learn about the correct way to examine these systems using the biomedical model (as agreed within the medical school). Basic anatomy and physiology and core communication skills and feedback skills, in order to work directly with students will also be learnt. By increasing awareness and understanding of each other's needs and goals (doctor/patient) it is envisaged that mutual consensus can be obtained on a more profound level. Patients can feedback to students about their technical skill and how they felt being examined by them, thereby meeting educational needs in that sense. It is proposed that if patients offer feedback about students' communication skills, this will in addition help students integrate their practise. Enlightenment is superior to dogmatism and this is the same for potential doctors and patients. It is proposed that this development of CATCH will also become a substantive embedded part of the communication curriculum.

6.16 CONCLUSION

This chapter has presented an example of a communication in healthcare curriculum. Much of the content and learning processes are in keeping with other curricula currently being developed in medical schools across the country. In addition it meets the recommendations for undergraduate medical education training in this regard.

Where CATCH differs significantly is that the theory underpinning effective communication rigorously supports the educational activity described as a means of helping to meet patients' communication needs in healthcare. It is grounded in human need and communication theory. Therefore the educational activity can be justified in these terms alone.

Inevitably, and rightly, a curriculum of this nature will be constantly evolving and developing. Any changing communication needs of healthcare users and the learning needs of health professionals, to enable them to meet such needs, will inform curriculum development.

CHAPTER SEVEN

CONCLUSION

Chapter one began by introducing a discussion on the level of general agreement there is about effective communication in healthcare and then went on to outline the main problems of communication. Two main categories of problem indicators and barriers to effective communication were identified in order to help structure an approach to the problem. These two categories were further divided into five themes, complaints, patient satisfaction, concordance, patient understanding and recall, and health outcomes. All were noted to be effected by antecedent communication and an increasing body of research continues to demonstrate this.

At this point in the discussion the central importance of the doctor/patient relationship demanded special attention. Sociological models of the doctor/patient relationship that had been developed over the last five decades, namely, Parson's consensus model (1951), Freidson's conflict model (1970) and Gerhardt's negotiation model (1987, 1989) represent the phases of thinking and influences in the sociological theorisation of the doctor/patient relationship. The balance of power and the nature of truth and trust in the doctor/patient relationship provided an additional perspective to analyse and understand doctor/patient interactions.

Recent approaches to the doctor/patient relationship have moved on from clearly demarcated paradigms, to focus on the interactions and communications between

doctors and users of healthcare. Others have criticised these new approaches for under-theorisation and the rejection of the substantive body of sociological theory in favour of description and a positivist search for those communicative qualities of the doctor/patient relationship that are predictive of positive health outcomes (Scambler and Britten 2001). Scambler and Britten also criticise this new pragmatism for the tendency to present the doctor/patient relationship as a series of individual de-contextualised acts or self-contained units that has meant a shift away from the macro sociological analysis.

The concern about meeting communication needs in healthcare and producing a comprehensive argument for the why and how of effective communication in this thesis resulted in a similar conclusion. The ideas have not been overly concerned with sociological analysis of the doctor/patient relationship and the use or development of theory in this regard. The major concerns about under-theorisation of communication in healthcare were the lack of a comprehensive communication theory to support the pragmatic component of developing effective skills practice and the effect this had on the credibility of the subject for academic study and research.

Moreover, as the NHS makes claims to be a needs based service, it seemed essential for academic argument to agree what these needs were. It became clear there was a need to debate what approach or model of health needs was going to be most appropriate. A theoretic structure to approach the problem was now clarified. In order to explore what the relationship between communication and health needs is the next step involved a search for further clarification on two counts in the first part of the thesis. Two

questions were posed. Firstly, what theory of need would be useful; and secondly, what theory of communication would help with the analysis of defined needs.

Chapter two went on to describe and demonstrate the value of a theory of human need which place health needs firmly within it and offers a framework for understanding and defining basic human needs. (Doyal and Gough 1991). Most importantly Doyal and Gough's approach lends itself to embrace the inclusion of human communication as an additional basic need alongside health and autonomy.

Health care structures and processes should therefore be designed and delivered in order to meet the basic communication needs of users. Explanations and reasons for why and how these are not generally met have been given. Doyal and Gough were influenced by Habermas' theory of communicative action (1981) in the development of their theory. Therefore it was a logical step to explore the works of Habermas further in the quest to research what types of communication would best provide basic need satisfaction of communication, health and autonomy.

This section of the thesis offers a new way of thinking about communication in human need theory. Communication has been argued as a basic human need in the same terms that health and autonomy have. It is hoped this will encourage further theoretic development of ideas with regard to human communication in need theory.

In chapter three Habermas' theory of communicative action and later works have been shown to be a useful approach to analysing communication in healthcare. Habermas provides a social theory to support the notions of 'patient centredness' in everyday healthcare practice. This requires the systems world of medicine to open up to the lifeworld of patients. Not only in one to one encounters, but also institutionally and collectively in the way that healthcare is organised and delivered. His rules for ideal speech are consensus oriented. That is to say, that validity claims lie in the consensus reached through the freedom to participate in discourse and express attitudes; that everyone has the right to introduce any proposal into the discourse and question the proposals of others; and that with positive rights there is the negative freedom of non-participation. No speaker should be coerced into participating from either inside or outside of the discourse.

Notions of power and truth were returned to and Habermas' interpretation of power within the state, politics, welfare and science as a dominating force that represses and distorts communicative action were discussed.

Critics of Habermas argue that he is naïve in underestimating the significance of language used by powerful groups and vested interests to control debates (Keat 1981, Lukes 1982) and the notion of ideal speech is just that – ideal and somewhat Utopian in nature (Zimmerman 1985 cited in Rasmussen 1990 ch.2 p.41). Even if this is so, Habermas does not underestimate the power that politicisation and scientisation has over the lifeworld. In addition, he pays mind to the negative effects colonisation of the

lifeworld has, with regard to the freedom of society, to express views that hold valid claims of truthfulness and rightness. He also makes it clear that there is a moral imperative to redress impoverishment of the lifeworld and to aim for consensus through communicative action.

Medicine claims truthfulness through objectively stated scientific discourse. This is how discourse has tended to be framed in public debate, even in the recent attempts to increase patient and public involvement in healthcare. Public participation requires a democratisation of decision making and Habermas' work provides a way of understanding that processes embedded in communicative action will help in this regard. In other words he provides the means but not the ends - not the answers themselves.

Some of the NHS reforms do appear to be moving in the right direction in terms of democratising public decision making, but it is too soon to know how these changes will work in practice and what the effect on patients will be.

Changes in decision making at the micro level, that is doctor/patient communications can be analysed in terms of asymmetries of power and distorted communication. It has been argued in this thesis that Habermasian analysis is helpful on both individual and collective levels. His notions of consensus and rational communication provide the means to challenge pre-existing patterns of predominantly strategically led systems based communication in medicine by questioning the rationality of continuing to

operate in an environment of distorted communication. Habermas does not concern himself overly with relationships issues, and therefore the sociological models of the doctor/patient relationship described in chapter one provide an important link with the other aspects of interactions that Habermas does talk about.

Habermas claims that linguistic interaction (communicative action) meet the demands of validity claims, whereas strategic action occurs when at least one of the participants aims to produce an effect on others, either in an open (influence declared) or concealed fashion (deception). Therefore, although there are undoubtedly problems in attempting to operationalise Habermas, his framework provides a tool to analyse communication in healthcare, especially decision making. This point has been made by others (Jones 1999). Therefore the intention was not to operationalise Habermas, but to use his theoretic approach to analyse and interpret communications in healthcare and apply his thinking specifically with regard to meeting basic needs of autonomy and communication.

To this end consensus in healthcare and notably informed consent procedures were focused on in chapter four. Habermasian analysis of consent procedures identified that in some respects on a collective level there seems to be a sincere effort on the system's world part to increase the lifeworld's voice in the organisation and delivery of healthcare.

On the other hand, medical practice in regard to consent procedures can only be said to be as effective if health professionals are themselves effective communicators. However, ridding medicine of the traditionally accepted practices of distorted communication is likely to require continuing attention. In the meantime, the situation is that patients may not have a real choice. The consequences of this state of affairs can be distressing or even catastrophic for patients and their families, as the Bristol Inquiry (2001) discovered. In the case of less dramatic examples there still remains the unavoidable argument for the protection and enhancement of individual needs for autonomy and communication and the right to need satisfaction on the basis of moral and rational thinking.

Medical education has been slow to respond to the problems of communication in healthcare despite the growing evidence base that shows the negative effect poor communication has on patient outcomes, and the strong moral argument for improving communication. This is interesting, as medicine is concerned with the importance of individual autonomy, and a good deal of medical ethical writing reinforces this.

The models of communication skills teaching and learning for health professionals described in chapter five provide examples of good skills based courses but communication has tended to be categorised as a skill only. Earlier concerns voiced regarding the lack of theorisation about communication in healthcare were returned to in this section of the thesis. Current thinking in communication skills in healthcare lacks clarity or consensus about a comprehensive theoretic foundation for the subject.

Communication has not been discussed as a need in and of itself, and the terms of reference have been almost entirely behavioural skills based terms. It has been comprehensively argued that this (theoretic) component of communication is vital. It has not been the intention in this argument to diminish or demote the pragmatic skills base for clinical communication. The argument is that clinical communication skills without a substantive theoretic underpinning could be open to a wide range of criticism. First it would mean that communication skills in healthcare, although gaining recognition as a central force in health professional practice and education, would remain some of the few skills that do not have a cohesive theoretic knowledge base to back them up. Indeed it is a struggle to think of any other clinical skills that can be learnt or practiced in this way with safety of outcome in mind. For example; physical examinations and procedures and interpreting medical imaging require knowledge of anatomy and physiology. Handling and using technical medical equipment requires a technical knowledge base. Infection control procedures require an understanding of biological cellular science and so forth.

Thus chapter six describes a strategic (as in plan of action, not as Habermas uses the term in communication theory) approach to teaching and learning communication skills in healthcare. The approach is a combination of theory and practice and is integrated into main stream medical curriculum, CATCH.

This thesis has identified that the relationship between effective communication and autonomy had not been sufficiently explored in both need theory and communication

teaching. Clear and explicit attempts to do this through the developing theoretic argument have aimed to do this.

Finally, my conclusion is that we haven't asked people what they need in healthcare. In the main, due to problems about agreeing what need is and a lack of communication theory and skills that equip health professionals to do so even when they do agree. Moreover, moves to increase democratic individual and public involvement in healthcare decision making requires effective change management through communicative action at all levels. NHS reforms and health professional education will need to work together before we can claim that we are asking people what they need. This thesis has aimed to provide an understanding and analysis of how far or near we are to making that claim.

Users of healthcare, that is you and me, have the right to be listened to, to give our views, to understand the implications of our illnesses and to choose appropriately in the light of mutual understanding. We all need these in order to protect our basic human needs. Watzlawick (1974) says 'we cannot not communicate', it is a simple and profound statement (even if it does break the rules of grammar with a double negative). It has been argued that our need to communicate is what makes us human and enables us to participate in society just as much as our need to be autonomous does. Needs based services therefore ought to include communication in the equation.

Modern societies are in a transition from the age of technology into the age of information and this will have profound effects on the role of human communication. The imperative to define communication, as a basic human need seems somehow to be vital in order that we are not seduced by the medium of the message or confused about what is important. Does the information meet communication needs; does it meet the demands of Habermas by being based in communicative action, and does it aim to protect and enhance individual autonomy? If it does all of these things then indeed we will be asking people what they need.

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APPENDICES

Appendix 1

CHAPTER 2 – NOTES

1) a) Braybrookes list of needs:

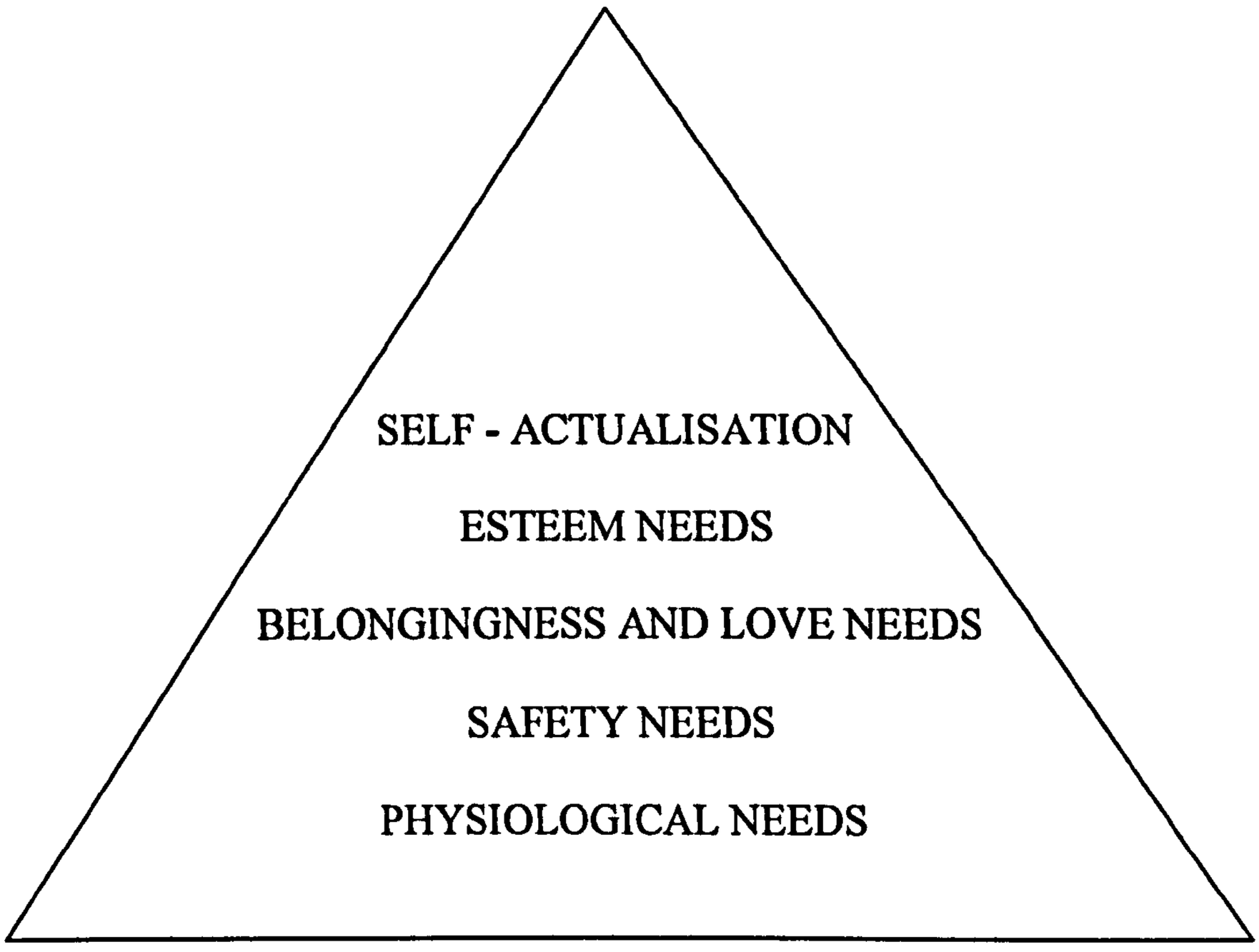
i) The need to have life support in relation to the environment
ii) The need for food and water
iii) The need to excrete
iv) The need for exercise
v) The need for periodic rest, including sleep
vi) The need (beyond what is covered under the preceding needs) for whatever is indispensable to preserving the body intact in important respects.

The second part, although concerned with physical functioning, has more to do with functioning as a social being. It includes:

vii) The need for companionship
viii) The need for education
ix) The need for social acceptance and recognition
x) The need for sexual activity
xi) The need to be free from harassment, including not being continually frightened
xii) The need for recreation

b) See the clear parallel with Ropers model of nursing based on a model of twelve activities of daily living. These include nutrition and fluid balance, sleep, exercise, sexuality and excretion. Nursing assessment includes how much the patients health problems impact on the activities in functional terms [Roper et al 1990].

2) Other theories of need are not covered in the text but are none-the-less important. Maslow's psychological approach to need is a hierarchical framework based on a theory of instinctive motivation. Maslow conceptualises human needs in terms of drives [Maslow 1943, 1967, 1987]. Maslow's model requires that lower basic needs must be satisfied in order to reach higher need satisfaction and this is illustrated as a pyramid.



Maslow describes his theory as a holistic-dynamic theory. He too tends towards a universalistic approach but societal and environmental impacts on need satisfaction are not recognised, or at least undeveloped. Maslow's theory of need is widely used in healthcare.

3) Bradshaw [1972] offers a theory of need from a sociological perspective. His approach is organised as a taxonomy of social need. Need is divided into four separate definitions.

i) Normative need – or need as defined by the experts or professional administrators.
ii) Felt need – defined in subjective terms as perceived by an individual.
iii) Expressed need – felt need turned into action.
iv) Comparative need – incorporating the fields of epidemiology, demography and social geography.

Need can be measured by any of the above, or in what amounts to twelve categories or combinations of need.

4) Other significant influences which are helpful in dealing with the problem of need are Rawls' theory of Social Justice [1972], and Habermas' theory of communication [1970, 1981]. Rawls offers a wider political framework of justice within

which to consider human need which does not reject modern capitalism but, like Braybrooke, places precedence on human need. Habermas' theory goes some way to helping with the problems of communicating need in objective and universal terms, which relativism does not. Habermas also addresses some of the issues around the encroachment of science in everyday life and what impact this has on communication. Habermas is discussed in his own right in the next chapter.

5) With regard to personhood pertaining to higher levels than merely surviving see: *Goodman MF. 'What is a person'* 1988, Humana press, Clifton, New Jersey. Especially Becker [p.74] who points out that a human being is more than a set of biological structures. He argues that it is loss of function, not structure that threatens personhood.

See also Dennet who offers six familiar themes each claiming to be necessary conditions of personhood.

i) Persons are rational beings
ii) Persons are beings to which states of consciousness are attributed, or to which psychological, mental, or intentional predicates are ascribed.
iii) Whether something counts as a person depends to some extent on an attitude taken towards it, that is we have to establish the objective fact that something is a person, and we therefore treat him in a certain way.
iv) The object identified as a person must be capable of reciprocating in some way.
v) Persons must be capable of verbal communication.
vi) Persons are distinguishable from other entities by being conscious in some special way.

Ethical issues must be raised when illness impedes any of these themes. For example a patient who has had a stroke may lose the ability to verbally communicate. There are also more recent examples of individuals previously diagnosed as being in persistent vegetative states who with skilled assessment and care have been discovered to be intellectually and emotionally unimpaired.

6) The other important aspect which will either enable or disable individuals and collectives as regards to opportunity to participate is communication. The very crux of this thesis. The German philosopher Habermas explores the concepts of democratic and rational communicative actions and is influential in Doyal and Gough's approach. These ideas include the concept of recognising experiential and codified knowledge and the ultimate right for both to be heard. These concepts are vital as preconditions for effective communication. Habermas is the main influence in the next chapter which concentrates on communication theory, so this aspect is left until then.

7) Out of Societal Preconditions

It is in society's interest to have political stability and not anarchy. The abstract concepts of political freedom can be broken down into the more pragmatic level of, for instance, the right to vote, have political ideas and argue about political decisions and be allowed to demonstrate or protest peaceably. But to argue about political ideals without a structure within which to frame them would result in revolution and chaos.

8) Dual Strategy of Social Policy

Doyal and Gough [p.141] suggest a more appropriate political approach to operate within the capitalist system of most of the modern western world: A dual strategy of social policy formation. I do not intend to spend much time on this aspect of human need but merely want to introduce the idea of dual strategy as this concept is mirrored in communication theory in the next chapter and in later discussions. The idea of a dual strategy to avoid social disablement includes giving people a voice. Normative, expert, or even one political party ought not to decide on public welfare. Morally [within the concepts of justice and fairness] and for effectiveness, codified and experiential knowledge about basic needs must be heard. A high degree of democratisation is necessary to support this state of affairs and to this end we need what is called a dual strategy of social policy formation.

> "It requires a dual strategy of social policy formation which values compromise, provided that it does not extend to the general character of needs and rights."
>
> [Doyal and Gough 1991 p.141]

Putting this in more concrete terms one can think of it this way. For a person to have the opportunity to flourish as an individual he must be enabled to participate as fully as possible in his social world. This means having the democratic right to be heard and make autonomous decisions about his own life. This takes us on to the idea of individual autonomy itself having already outlined the conditions needed to support and sustain autonomous growth.

9) Needs and Goals

Within the theory of need postulated by Doyal and Gough it is possible to get confused over need and goal in relation to autonomy. We might get wound up in the circular assertion that we need to survive in order to have the goal of autonomy, we need autonomy in order to develop as an individual. The concept of time comes in here. To reach optimum levels of autonomy we need time. We need basic autonomy to shape our lives, to make more of it. To reach any potential we need critical autonomy to become a flourishing person and this happens over time. If something is needed, then by definition it is a necessity, and there is little room for argument or alternative action. Whereas, if something is considered in terms of a goal there may be many influences along the way which may impede or assist in the attainment of the goal. Autonomy can still be defined as a basic need because it falls in the category of being a pre-requisite in

order to avoid serious harm as has been defined. Previously, the need was defined as something, an intervention, structure, process, whatever, to avoid serious harm. It has also been argued that autonomy is needed to avoid disabling individuals socially, and to disable someone is to cause harm. Therefore, basic autonomy holds its own as a need. It is still possible, however, to aim for increased or optimum levels of need satisfaction.

Note for reader:

Appendix 2

In the interests of space selected examples of sessions and learning methods are included in this appendix. Please note this is not the entire curriculum.

Examples of Communication Skills Sessions from Year's One to Five

CONTENTS

COMMUNICATION IN MEDICAL PRACTICE: BASIC COURSE

September 2003

Thank you for helping to facilitate student learning in the first part of the Communication in Healthcare curriculum. Part of the student's learning will now take place in the Interprofessional Education course (IPE). The IPE course provides an opportunity for students from a range of healthcare disciplines to develop effective team-based approaches to patient care. The learning objectives of the IPE communication sessions are included in this pack to provide an overview of the student's learning. Facilitation guidelines for the remaining sessions taught, in years one and two within the medical course comprise the remainder of this pack.

At this stage of the course, students are expected to develop awareness and a sense of responsibility for their own communication; and to practise the skills which enable them to develop good relationship skills with patients and explore patient's health problems within an ethical framework. Students will have the opportunity to interview patients in both General Practice and hospital settings in years one and two.

ELAINE GILL
Head of Communication Skills Unit

MBBS SESSION 1:
INTRODUCTION TO COMMUNICATION SKILLS IN HEALTHCARE AND PATIENT INTERVIEW BRIEFING

This introductory plenary session will outline the basic principles of communication in medicine.

- Why do we have a communication curriculum?
- What are the main problems in communication?
- What are the opportunities for shared learning in communication and clinical skills?
- How is the Patient-Centred Interview Skills Guide to be used?

THE MAIN AIMS OF THE SESSION ARE:

- To give an overview of the role and impact communication has in health care.
- To outline some of the problems in communication between health care professionals, patients and relatives.
- To outline how communication between healthcare professionals and patients effects patient outcomes.
- To give a brief overview of the structure; process; teaching and assessment methods in the communication curriculum.
- To invite students to take an active part in course developments student representatives in any relevant meetings and forums and to discuss issues with staff in the Communication Skills Unit directly.
- To distribute IPE questionnaire.
- To give students instructions for their forthcoming patient interview in out-patients.*

*Students will be allocated to clinical areas where they will interview patients in pairs. They will give feedback to each other after the interview on their communication skills. Students will be required to submit a reflective account of the interview which carries 5% of course assessment marks.

MBBS SESSION 2: PRINCIPLES OF FEEDBACK

Thank you for helping to facilitate student learning in the MBBS Year 1 Communication in Healthcare curriculum. Whilst this session is uni-disciplinary, the students will shortly be introduced to 'core' communication concepts in the Interprofessional Education (IPE) sessions taught jointly with students of the other healthcare disciplines.

The purpose of this session is to introduce students to the concept of feedback. This serves as preparation for the coming sessions where students will be learning through role play with simulated patients and also to prepare them to use feedback effectively in a professional capacity.

LEARNING OBJECTIVES

On completion of this session the student should be able to:

- List the key principles of giving and receiving feedback;
- Develop a sense of professional responsibility for their own communication;
- Identify mechanisms of feedback at an interpersonal and institutional level.

TUTOR NOTES

Begin the session by asking the students what they understand by feedback and what purpose it serves.

After getting their ideas you can offer a summary of the purpose it serves:

- To give the individual information to help them recognise what they have done effectively
- To suggest ways of doing, or thinking about, something differently in order to be more effective in the future
- To help them to identify learning and personal development needs
- To assist in learning, clinical and professional development.

Contd…

OTHER AREAS TO BE COVERED IN THIS SESSION

Feedback mechanisms:

Ask the students to describe modes of feedback through which they may receive or give feedback. Fill in any missing modes, eg verbal, written, electronic (virtual campus), representative bodies such as SMEC.

Describe the 'What and How' of feedback:

1) Feedback is not the same as criticism. Feedback is necessary in the processes of teaching and learning. Feedback is a skill and involves informing another of your observation of his or her behaviour. It is not about commenting on an individual's persona or identity. Feedback should be concentrated on what somebody has actually done behaviourally.

2) Allow the student to talk first and offer a self-critique.

3) Focus on the positive first and use descriptive terms.

4) There may be a difference in the intention of an individual and their behaviour. In other words we may intend to achieve something, but our behaviour does not meet the original intention. It is useful to separate behaviour from intention.

5) All feedback is subjective. Always make your comments in the first person. The person receiving it may disagree.

6) Individuals can only take in a few comments at a time. Keep to a few points and don't overload the content.

7) Be specific. Saying 'that was good' is not enough. What specifically was good, what did the student do, how did he/she do it? What was the effect of the good communications?

Describe how this is used in Communication Skills Unit teaching sessions. Finish with a discussion of how to feedback within the institution of the medical school. i.e. specific evaluations of teaching sessions and clinical placements, feedback on virtual campus, representation on year committees and SMEC involvement.

Main point: Specific and constructive feedback is more likely to be effective than general and/or destructive feedback.

CURRICULA LINKS TO IPE

How the various discipline's curricula links to the core Interprofessional Education Programme

Medicine

Interprofessional Education embodies the recommendations of the NHS Plan, Tomorrow's Doctors, health professional bodies and other agencies which set out objectives for the delivery of modern healthcare. In the 21st century, the patient is considered to drive the development of the NHS which is in contrast to the 20th century when healthcare was dominated by the needs of government and health professionals.

Modern health professionals will be required to work effectively in teams to provide patient-centred care. Therefore, the focus of IPE is the patient. Our main aim is to maximise effective patient care through developing good team-based approaches. In order to reach this goal, students will be encouraged to learn and work together during their training.

IPE is an integral part of the medical undergraduate curriculum at GKT. In Year 1, medical students have the opportunity to work with other health professional students – nurses, midwives, pharmacists, physiotherapists, dentists and dieticians.

The two topics that are introduced through IPE during Year 1 are Communication in Healthcare and Healthcare Law and Ethics. Core topics and generic principles common to the seven professional groups are delivered by lectures, small group work, demonstration and practice. Medical students will have first-hand patient contact within their first few weeks of medical school.

IPE will be further developed in clinical attachments later in training.

Nursing

Florence Nightingale School of Nursing and Midwifery have 2 intakes per annum. The largest is the 3 year programme for approximately 400 students who enter in September and undertake either a Diploma or BSc (Hons) with registration as a nurse in Adult, Child or Mental Health. A smaller group of approximately 80 students who hold a Health related degree enter in July for an accelerated 2 year programme.

In year 1 students spend 18 weeks in practice placements and the remainder of time in College. ***Interprofessional working*** and ***ethics*** is introduced in the Developing Nursing Practice course, where the ***IPE*** assessment is located. Awareness of self in

communicating with patients and ***utilising information*** is addressed in the Information for Nursing Care course.

The management courses undertaken in years 2&3 in the Branch further develop ***Interprofessional partnerships*** and ***team working***. All students study ***health information*** within the Health Promotion course in Year 3. Competencies in relation to effective ***Interprofessional working*** are assessed in practice placements during the branch programme.

Midwifery

Level 1: 15 Credits. Within the first year of the DipHE midwifery education programme student midwives will join the other healthcare professional students across the University for Interprofessional Education (IPE) Clinical Communication and Ethics Course. They will attend all the sessions relating to communication skills, critiquing health information leaflets, ethics and confidentiality. However, the student midwives will be taught separately for additional sessions where the content will focus specifically on topics relevant to interprofessional working in midwifery practice.

At the end of the IPE course, student midwives are expected to complete a summative assignment exploring: **communication skills in the delivery of midwifery care,** 2,500 words (maximum).

Dentistry

The Interprofessional Education course is an important component of your learning in dentistry. It complements your learning in Applied Dental Science where the focus is on acquiring the interpersonal and practical knowledge and skills to become a good dentist. Working as part of a multi-talented team and working effectively with other health-care professionals will be invaluable to you in your career both here at Dental School and once you have graduated. Your tutors in Applied Dental Science have worked closely with the IPE staff to ensure that all the teaching experiences in the two courses work together. As part of ADS you will have the opportunity to interview a patient and your reflective account of this process will form the requirements for your IPE course.

Pharmacy

Interprofessional Education for pharmacy undergraduates is introduced during their induction course in the first week of the first semester. This is reinforced by a week of IPE in week 3 of the Autumn semester.

Every Wednesday morning in the first year are reserved for IPE training to ensure full participation in this important initiative.

In order to bring IPE to life, a patient interview assignment is issued to pharmacy students to complete over the Christmas break. They are given a letter to introduce them to a local pharmacy, explain the scheme and ask for cooperation. With the help of the pharmacist, they identify a suitable patient to interview. The interview is written up from a 'communication skills' perspective, and there is also mention of the medication.

In 2003/4, IPE attendance at tutorial/workshop sessions will be made compulsory and students will be told to expect examination questions, to emphasize how important we see this aspect of the pharmacy course.

Physiotherapy

Interprofessional learning in physiotherapy takes place in both college and clinical practice settings and is a strong feature at each programme stage. The common foundation lectures and group work described in this handbook form part of the first year unit entitled "Introduction to Psychosocial Aspects of Health". The main aims of this unit are to:

- emphasise the importance of positive and supportive interaction between client and therapist
- enable students to begin to prepare for their future roles as therapist, teacher, health educator, counsellor and health care team member
- promote the importance of developing team skills needed for effective and collaborative practice that is focussed on concerns of the client

Interprofessional learning in practice begins with clinical observation visits in year one, semester two. During the course of these visits, physiotherapy students undertake work in preparation for the interprofessional learning assignment.

Important learning outcomes of first year clinical education (August/September 2004) will be to recognise the role of the physiotherapist within a number of different health and social care teams and to begin to develop the skills of collaborative practice. As both college-based and clinical learning progresses in years two and three, students will learn about and experience their team roles and responsibilities in the many diverse settings and circumstances in which physiotherapists practice.

Dietetics

The programme for first year students in dietetics includes a course (Introduction to Professional Practice) designed to introduce you to the attitudes, skills and behaviour required in relation to patients, the public and fellow health professionals. In order to ensure continuity of care and integrated effective management of patients, it is increasingly important that healthcare professionals work together and understand each other's perspective. There are themes which underpin the development of professionalism in all healthcare disciplines and it is particularly valuable for students to learn about these together.

As a result, this course includes an interprofessional element (IPE) undertaken with students from other health disciplines (medicine, dentistry, pharmacy, nursing, midwifery and physiotherapy), in addition to material specific to dietetics. These IPE elements provide an opportunity to consider topics such as ethics from a range of viewpoints in discussion groups and also to start building up practical experience of aspects communication with patients, which can affect the effectiveness of all disciplines.

SESSION 1 : PLENARY
ETHICS AND COMMUNICATION IN HEALTHCARE

INTRODUCTORY SESSION

The main aims of this session are:

- To outline the recent national and local initiatives and recommendations for IPE.
- To list the main concepts and topics covered in the subsequent sessions
- To give a brief overview of the structure, process and teaching and assessment methods of the year 1 IPE programme;
- To ensure all students have their IPE packs including following information:
  - Their designated IPE group
  - Their personal timetable
  - Designated venues for each session
  - Session topic titles and learning objectives
  - Tutor contact details
- To provide a case study presentation to illustrate multidisciplinary input and team approaches to patient/client care.

SESSION 2a : CORE COMMUNICATION SKILLS

LISTENING, RAPPORT & EMPATHY AND QUESTION STYLES

LEARNING OBJECTIVES

On completion of this session students should be able to:

- Describe in behaviourally stated terms the process of effective listening
- List factors which are likely to block effective listening
- Describe in behaviourally stated terms the process of establishing and maintaining rapport
- Identify factors which are likely to break or block rapport
- Describe in behaviourally stated terms ways of demonstrating empathy
- Demonstrate the use of open and closed questions

1. LISTENING

IS LISTENING A TEACHABLE SKILL?

"Listening is perhaps the least developed of one's comprehensive skills". [Smith V. 1986]

Yet listening is the most used communication skill. An individual will typically spend 70 - 80% of waking hours in verbal communication activities. Of this nearly half will be spent listening.

There are many definitions of listening from different scientific and psychological perspectives. The common link with the definitions is the importance of understanding and interpretation of information. Listening is therefore more than a simple process of hearing and is an active process which people choose to engage in.

WHY LISTEN? [Ask the students].

Listening is used in multiple ways for different purposes. We often listen to gain different sorts of information simultaneously. Some of these are:

- To empathise with another
- To discriminate and clarify information received
- To evaluate or confirm
- To be acknowledged - either as an individual, or for something we have actually done, or for an opinion or belief we hold.
- To appreciate - music, the spoken word etc.

We also find ourselves responding in different ways depending on the content and context of the information. For example there may be a high level of emotional information or factual abstract information. A sensitive listener will respond differently to emotional content in interactions than abstractions.

DEVELOPING LISTENING SKILLS

Most people can improve their listening skills. Memory and recall can often be improved by techniques to help with the organisation of information and material and visualisation. These are the types of skills that are particularly useful in learning situations. For example remembering formulae and abstract information. These skills are less helpful when listening for information about how another person is feeling, what their worries or concerns are or what they believe about, for example, a health problem. Listening skills in this sense are more to do with encouraging the individual to expand on their concerns and checking for subjective understanding of meaning. These skills are also useful when developing a relationship, be it personal or professional.

The relationship based skills are what we will concentrate on during the first part of the IPE programme. These types of skills are generally called interpersonal or social skills and are a combination of verbal and non-verbal behaviours.

We all know people who we would call 'good listeners', but what is it that they actually ***do*** which makes them good listeners. The first exercise is for the group to generate through brainstorming 'what makes a good listener'.

EXERCISE in groups of 4-6 + main group {total time 20mins}

a] Identify some non-verbal behaviours which would indicate to the other person that you are receptive to their communication.

{5mins}

b] Identify some verbal communication skills which demonstrate to the other person that you are receptive to them and are paying attention or 'actively listening' to them. {5mins}

c] Invite each group to disclose what they have come up with and then open out to the main group for discussion. {10 mins}

TUTOR NOTES

1) Non verbal: *hopefully the students will come up with some of the following and others. If not, give prompts. For discussion, concentrate on 2 or 3 of the following:*

Eye contact, length of gaze, facial expressions, use of silence, body position, body movements, hand - face contact, pitch, pace and tone of voice, response to emotions demonstrated, response to distractions.

2) Verbal: *repeat the process with verbal skills*

Paraphrasing, reflecting, avoiding ambiguity, clarifying, avoid unnecessary interruptions, use appropriate question styles.

We need to be aware of the non-verbal messages we might be giving.

We need to be receptive and patient and not jump to our own conclusions.

OTHER CONSIDERATIONS FOR GENERAL DISCUSSION

- Environment - physical space, privacy, noise.
- Time and timing.
- Cultural and language differences
- Attitudes – the way we behave tells others something about our attitudes

NEGATIVE OR POOR LISTENERS [10mins]

Ask the students if they recognise any of the blocks to listening (see next page). They may identify with some of these behaviours themselves, people they know, or experiences they have had which fit these categories. Try not to get tied up in lengthy debate over this section - you will run out of time otherwise.

Listening

Blocks to Listening [students have this in their pack]

McKay et al have identified the following 12 blocks to effective listening. Can you identify any particular traits from those listed below that you have a tendency to use in your personal communication style?

1. **Comparing:** e.g. 'Could I do it that well?' 'When my mother died I coped much better'.

2. **Mind reading:** Trying to figure out what the other person is really thinking or feeling

3. **Rehearsing:** Giving attention to the preparation and delivery of your next comment

4. **Filtering:** Listening to some things and not to others

5. **Judging:** Not listening to what they say, as they have already been judged

6. **Dreaming:** Half listening while something the other person says triggers off associations of your own.

7. **Identifying** Referring everything the own person says to your own experience

8. **Advising** Being the great problem-solver, ready with help and suggestions. You don't have to hear more than a few sentences before you begin searching for the right advice.

9. **Sparring:** Arguing and debating. You disagree so quickly that the other person never feels heard. You take strong stands and are very clear about your beliefs, values and preferences.

10. **Being right:** Going to any lengths to avoid being wrong. You can't listen to feedback or take suggestions so you continue to make the same mistakes. No acknowledge areas for development, you repeat previous patterns of behaviour.

11. **Derailing** Changing the subject suddenly. You derail the train of conversation when bored or uncomfortable or laugh it off.

12. **Placating** e.g. 'Right...right...absolutely...I know...of course you are.... incredible ....yes....really'. You want to be nice, pleasant, supportive. You want people to like you. You half listen, probably enough to get the drift, but you don't get involved. You placate rather than tune in. You don't examine or explore what's being said.

(Adapted from McKay, Daws and Fanning in Messages (Communication Skills), New Harbinger Publications, 1983).

CONCLUDE THIS SECTION WITH THE MESSAGE THAT:

Effective listening is using both non-verbal and verbal communication together in as optimum environment as possible in any given situation. That is to say we will not always have an optimum environment and time may be at a premium, but it is useful to be aware of the variables which affect listening and indeed other communication skills.

EXERCISE

The group breaks up into sub-groups of 4 students per group. Each student has a role to play in the exercise.

a] **Student 1 will choose a topic to talk about for 3mins. The choice is the students - it can be an interest, a problem, something that happened to them, or someone they know. The provisos are that the subject chosen is small, not a life event and fairly low in emotional content.**

b] **Student 2 will listen. The student will be encouraged to behave as naturally as possible and respond in the way he/she normally would in a conversation.**

c] **Student 3 will observe student 2 and note what he/she does during the conversation. Verbal and non-verbal communication should be included.**

d] **Student 4 will observe the communication process, and what goes on between the two. Again verbal and non-verbal information should be included.**

Following the exercise the students feedback to each other. Starting with student 1, then 2, 3 and 4. The students are encouraged to discuss what they felt and observed. Judgment statements are to be discouraged.

The groups then feedback to the whole group. The tutor's role in this exercise is to highlight what they are doing well naturally and therefore identify the communication skills they already have and will be able to develop.

- The importance of listening with an open mind.
- The importance of effective listening skills in healthcare practice.
- The level of emotional content in the other person's message.
- The need to discriminate between emotion, fact, and opinion.
- Any discrepancy between verbal and non-verbal messages.

Listening is an active process in multi-level interpretation and understanding.

2. RAPPORT AND EMPATHY

One of the purposes of effective listening in a healthcare interview is for the health professional to attach meaning to the messages the patient is giving, and to understand how the patient views and experiences their health problems.

This entails developing a relationship with the patient. Health professional-patient relationships will vary depending on the clinical context, whether they are new to each other, how often they meet, the context and specialty, what expectations does the patient have and so forth.

Generally speaking health professionals need to establish a good relationship with their patients fairly quickly, sometimes instantly. This is called establishing rapport.

WHAT IS RAPPORT? - Ask the students

Rapport is a term which encompasses the concept of feeling comfortable with another person. Such phrases as: *"we just seemed to click - she was on the same wave-length as me - I felt really at ease"*, describe a sense of rapport between two people. Rapport is essentially identification of similarities between individuals. The messages of similarities may be subconscious.

WHAT DO YOU DO TO ESTABLISH RAPPORT WITH ANOTHER?

EXERCISE [15mins]

Break the students up into buzz groups and ask them to:

a] Identify communications which might help to establish rapport. They might like to think of this in the context of health professional/patient context.

b] What factors might get in the way of establishing rapport? [5mins]

c] Feedback to the rest of the group and discuss. [10mins]

DO WE ALWAYS NEED TO TRY TO ESTABLISH RAPPORT WITH PATIENTS? – Ask the students

EXERCISE [10mins]

With the whole group or in buzz groups again. (As facilitator, you may like to consider whether or not to change the buzz groups depending on how the groups work). This debate may need quite a bit of support and prompting from the facilitator

If the answer is 'yes', then why? Likewise, if some people do not see the necessity then perhaps they could say why.

In the context of the health professional/patient interview

1. Greet the patient
2. Introduce your self
3. Clarify your role
4. Obtain the patient's name
5. Demonstrate interest and respect, attending to the patient's physical comfort and space
6. Be observant of non verbal cues re: the individuals emotional state.

[adapted from Silverman et al. 1998]

At this point there ought to be level of consensus agreeing that trying to establish rapport with patients is a good idea. Certainly in as much as all patients have the right to be listened to and treated with respect. Health professionals also have a responsibility to try and understand what the patient's health problems mean to them as individuals and how their lives are affected. Then it is time to move on to consider how rapport is maintained. This brings in the concept of empathy.

WHAT IS EMPATHY? [Ask the group].

Ask the group for their ideas about empathy and acknowledge what they come up with [if anything]. Then you can offer a definition if you want to.

Empathy is more than a general interest in the person and his/her problems. Empathy can be defined as:

- *"Being attuned to the way another person is feeling and conveying that understanding in a language he or she can understand."* [Anthier 1986]

It is a 2 way process:

- *1] The understanding and sensitive appreciation of another person's predicament or feelings.*
- *2] The communication of that understanding back to the person [patient/client] in a supportive way. [Silverman et al. 1998]*

- 'Seeing something from another person's perspective', 'putting yourself in their shoes' are terms which can be used.

- The notion of language needs to incorporate non verbal communication in order for it to be received as an empathic response from another.

Ask the students to give examples of how you might demonstrate empathy both verbally and non-verbally.

Eg: **Verbally:** "That must be difficult/distressing/upsetting/worrying etc... for you".

Non-verbally: leaning forward slightly, nodding appropriately, changes in facial expression, changes in voice pitch, pace and tone etc.

In the context of a health professional/patient interview

Welcome the patient warmly

Clarify patients ideas, concerns and expectations

Listen

Encourage expressions of thoughts and feelings

Check interpretations and assumptions to aid understanding

Use non-judgmental responses

Use silence

Encourage the patient to contribute and ask questions

Offer choices and reach mutual agreement

3. QUESTION STYLES

HOW CAN WE USE QUESTION STYLES TO HELP US?

If empathy is about putting yourself in someone else's shoes then we have to explore with them how they view, or what they believe about an experience. 'What is it like for them.' The following examples are common question styles used in interviews.

a) Open questions

Using open questions is a useful skill in encouraging someone to answer in their own way and give you the information they feel is important. Open questions are non-directive and allow for a wide scope answer. Open questions are generally used at the beginning of medical interviews to help the patient explore their problems and to share this information with you as the health professional.

Ask the group to volunteer with some examples: e.g. "*Could you tell me a bit about what is bothering you at the moment*" or *"How can I be of help?" "Tell me a bit more about that?"*

b) Probing questions

Probing questions are useful in order to follow up initial opening and exploring questions. These are also used as part of clarifying information and meaning.

Ask the group to volunteer with some examples: *e.g. "What exactly do you mean by...?"* or *"How would you describe the pain?"*

c) Closed questions

Closed questions are generally appropriate when you need to focus and reduce scope. Closed questions tend to result in a 'yes' or 'no' answer. Therefore it may be useful to use closed questions when you want specific information and towards the end of an interview or conversation when you are preparing to finish.

Ask the group to volunteer with some examples: *e.g. "Do you feel sick?"* or *"Do you have a headache?"*

POTENTIAL PROBLEMS WITH QUESTIONS WHICH MAY LEAD TO THE BREAKDOWN OF RAPPORT?

a) Leading questions

Leading questions tend to be reduced in scope and channel the patient in the direction you want them to go. Leading questions should be used with caution.

Ask the group to volunteer with some examples: *e.g. "Is the pain sharp or dull?"* or *"I expect you want to go home now don't you?"*

b) Other potential problems with questions

- Poor timing of questions.
- Inferred value judgement in the question.
- Asking questions to meet your agenda alone.
- Too many questions.
- Too many questions in the same style.

Summarise and conclude this session. Take a few minutes to outline the demonstration interview which takes place directly after this session. Encourage students to link their learning from this session with their observations of the demonstration interview.

SESSION 2b :
HEALTH PROFESSIONAL – PATIENT/CLIENT INTERVIEW

IPE Core clinical communication and ethics in healthcare course – Year 1 health professional students

This short [no longer than 10 - 15mins] health professional – patient/client interview provides an opportunity for students to see the core communication skills outlined in session one demonstrated in practice.

Learning objectives

On completion of this session students should be able to:

- Identify listening and relationship skills in an observed health professional-patient/client interview.
- Link the demonstration with session 1 'core communication skills' and 'the patient centred interview skills guide'.

Core skills in session 1

- Listening
- Developing rapport
- Demonstrating empathy
- Question styles

Linked ethical concepts that students will cover in this course are:

- Confidentiality
- Truth telling
- Consent
- Autonomy

The interview needs to be a generic 'exploring problems' type of interview. [e.g; please try to avoid doing a systems history or nursing assessment format.] A demonstration of how a health professional elicits patients/clients ideas, concerns and expectations and responds to these is the main purpose of this demonstration interview. Although the students will focus on the core skills listed above, you will hopefully demonstrate to the students how to summarise and conclude the interview as these are skills they will be covering in follow up sessions. At this stage we are concentrating on developing core skills before we move on to clinical communication tasks such as explaining a problem or taking a history. See attached the patient centred interview skills guide which is used as the framework for developing generic patient interview skills. Referring to this may be helpful for both you and students when identifying skills used and the affect on the interview process and outcome.

Points to focus on and to help you are:

- Opening the interview – reflect on introductions, when and how they affect the interview process.

- Demonstrate how open questions in the initial stage of the interview encourages the patient/client to tell her story.

- Demonstrate and highlight a variety of question styles and reflect back to the students how different question styles are appropriate for different information purposes i.e. wide range, non specific to focused short yes/no answers.

- Highlight and encourage students to reflect on the non verbal communications that have been observed during the interview [eye contact, sitting position, facial expressions, gestures, tone and pitch of voice etc.] Also to observe the patients non verbal communications and responses.

- Encourage and facilitate the students to reflect on any behaviours they observed which relate to rapport between you and the patient/client and identify empathic responses that you demonstrated.

- Allow students to ask you and your patient/client questions.

Each group has ½ hour allocated and you will have 2 groups making the session 1 hour in total. You will need to keep strictly to time so that both groups have a full 30 minute session.

Suggested time frame for the session

1. Introduction of health care professional and patient/role player – 5mins
2. Demonstration of interview – 10mins
3. Discussion, feedback and questions – 15mins. [You may wish, if the patient/client is willing, to demonstrate alternative ways of handling part of the interview or encourage students to come up with alternatives during discussion and feedback.]

If you have any further queries please do not hesitate to contact elaine.e.gill@kcl.ac.uk or tel: 020 7848 6350/3.

PATIENT INTERVIEWS IN DESIGNATED CLINICAL AREAS AND PHARMACY

NB: The briefing session for students' first patient interviews will be carried out within each discipline's own timetable. This can be delivered in a plenary format in a large room or lecture theatre. Please check your timetable for date, venue and time of this session for your own discipline.

Each discipline lead IPE tutor will be responsible for the allocation of the briefing tutor.

The task itself will also be timetabled within each discipline's own timetable. Check as above.

THE TASK

Your task is to interview a patient in a designated clinical area or pharmacy. You will be allocated a specific venue and time. Please stick to your allocation and time.

THE PURPOSE

The purpose of this interview is for you to work with your partner and observe the communication process and skills used during the interview. Do not try and behave differently, talk to the patient and listen to their responses in your own natural style. Your partner will give you some feedback after the interview and you will do the same for her/him. Take turns to interact with the patient and observe each other. The two of you can help to raise each others awareness of what communications skills you use effectively already and consider skills you might like to develop or do differently in the future. You are not carrying out a medical interview.

Ensure you:

1] Explain to the patient the purpose of your request to talk with them.

2] Gain verbal consent from the patient.

3] Focus on the communication skills you are using.

4] Remain aware of lack of privacy if you are not in a consulting room. Where possible move into an area with space.

Points you might like to focus on

- Do they know why they have been referred?
- Do they know what to expect during their appointment?
- What do they believe their main problem is?
- Is their anything in particular they are worried about in relation to their health problem?
- What would they like to know?
- How do they feel at the moment?

Do not try to cover all these points, they are just some ideas. If it feels natural to talk about other issues raised by the patient then do so.

REFLECTIVE COMPONENT OF CORE CLINICAL COMMUNICATIONS COURSE

Guidelines for Reflective Diary

You may find it helpful to write a short personal reflective account of how you experience each communication session. Write a thoughtful account with as much personal disclosure as you feel comfortable with, it can be in note form. This does not form part of your assessment but is for your personal portfolio. (Space has been provided for this overleaf).

What is reflection?

The process of reflection incorporates considering not only what you have done in the behavioural sense, but also what effect an experience has had on you. What did you feel as well as what did you think. So you will need to think about yourself as well as your patient. The term 'personal disclosure' simply means how much of what you feel and think do you feel happy to talk about or write down.

Why?

Traditionally medical education has not incorporated reflective processes in the main stream curriculum. This is now changing. You will see in the literature the term 'reflective practitioner' as a description of a progressive health professional. In order for you to become reflective practitioners in the future we will be encouraging you to become familiar with the process as learners.

REFLECTIVE NOTES

Session 1: Introduction

Session 2a: Listening Skills, Rapport and Empathy, Question Styles

Session 2b: Observing Doctor-Patient Interview in General Practice

Session 3: Communication & Ethics

Session 4 Patient Interview (this will be recorded in your reflective written account for your coursework

GUIDELINES AND INSTRUCTIONS FOR REFLECTIVE ACCOUNT OF PATIENT INTERVIEW

Points to reflect on with your partner and for writing up the interview:

- What were you trying to achieve during the interview?
- Identify and give examples of listening, establishing rapport, demonstrating empathy and question styles used during the interview. What effect did these have on the communication process?
- How did you feel at the outset, during the process and at the end of the interview?
- What feedback did your partner give you?
- What have you learnt from the experience?

The account of your patient interview will be submitted as part of your course assessment. You are advised to write your account as soon after the interview as possible following discussion with your interview partner. Part of the marks will come from the content and part will come from your presentation. You will lose marks if it is not typed on a word processor. You are expected to write about 2,000 words.

Students are encouraged to write their account as soon as possible after completing their interview and to hand in their work before the date printed below. Work will not be accepted later than this unless you have proof of mitigating circumstances. You will be given a receipt *(** unless otherwise stated **)* for your work when you hand it in – keep this safely. (If a receipt is expected, do not hand in your work unless you are given one). **You must also keep a copy of your work,** either on disc or on paper until you receive your mark.

Please see overleaf details of where and when your account is to be handed in to your particular discipline.

ETHICS : Sessions 3, 5 and 7

TUTOR NOTES

Thank you for acting as tutor for the IPE ethics and law seminar. There are three lectures and two discussion seminar/tutorial sessions following the second two lectures. The **lectures** are:

1. Confidentiality (IPE Session 3)
2. Consent (IPE Session 5)
3. Autonomy, paternalism and truth-telling (IPE Session 7)

The plan of the **discussion** sessions is that the first discussion session (IPE Session 5) should look at consent and confidentiality, the second (IPE Session 7) at aspects of all the issues. Thus the discussion sessions will be incremental.

The format of the discussion series is tutor introduction, then breaking up into sub-groups which the students run themselves while the tutors move from group to group in the background, then a plenary. We suggest breaking the group into subgroups of 4 or 5 students, each subgroup containing a mix of professionals. Each tutor then helps with clarification and process issues as s/he goes round (i.e. is the group stuck/bored/off track? Are they confused by something? Is one person dominating?) The questions to be answered are as given, but obviously there may be other concerns which need to be dealt with. Feedback should be brisk, and non–repetitive (if an issue has already been stated, don't state it again). Then the plenary addresses issues and brings together ideas for the **students** to go away and check for themselves in their own professional codes etc.

One problem. We have been allocated rooms holding **two** groups (because of availability) so each group will have to be placed together at the beginning of the session (to avoid the students falling back into professional groups) and tutors will

have to allocate a lead tutor to run the introduction and the plenary. We suggest one tutor to be lead, another to keep time in the introduction, another to lead the plenary session and another to keep time in the plenary. Modelling professional debate in the final plenary would be fine provided you don't overrun the time.

We have drawn the session graphically overleaf.

FLOWCHART FOR ETHICS SESSIONS 5 & 7

75 seater room

Stage 1a : GETTING SEATED : APPROXIMATELY 10 mins

- Tutors check they have the right two groups

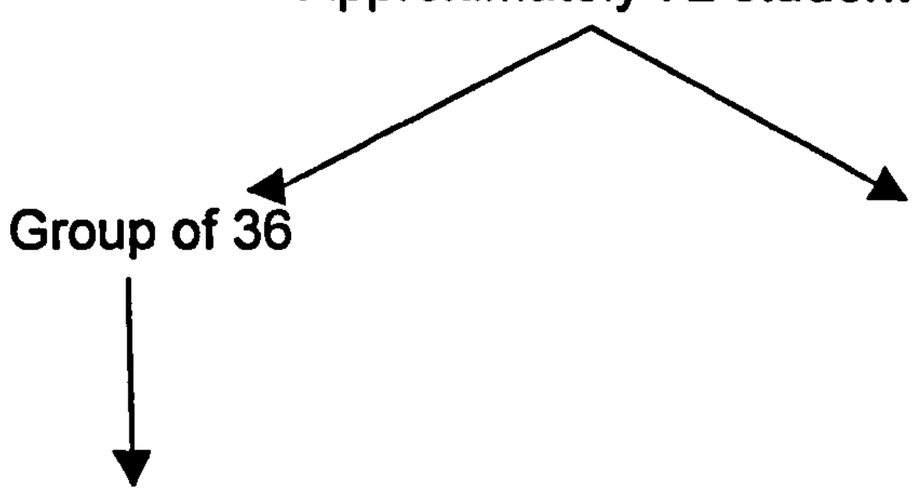
Stage 1b : INTRODUCTION and EXPLANATION

If there are two tutors - one tutor to lead introductory process and the other to time and maintain the process.

- Introductions to cover:
  - ➢ introduction of tutor(s)
  - ➢ any factual problems from lectures
  - ➢ explanation of aims of sessions
  - ➢ explanation of tasks
  - ➢ divide into subgroups

Stage 2: DISCUSSION : APPROXIMATELY 30 MINS

Approximately 72 students



- sub-groups MUST be mixed professionals
- tutors circulate to clarify tasks/process as necessary
- each discussion is in 2 or 3 parts, introduced by an overhead
- timing important

Stage 3 : PLENARY : APPROXIMATELY 10 MINS

- Feedback (non-repetitive) to plenary leader
- Discussion of issues
- Closure and reminder of next step: where to go with discussion and asking each student to refer to own professional guidelines to check details and make sure that s/he understands them

The cases deliberately start with student-centred issues in IPE Session 5 and become more "professional" in IPE Session 7.

The law gives some tutors a problem. We suggest it should be approached by asking:

a) what would you want the law to say?
b) what do you think the law says?
c) clarification of what it does say if you know, and if you don't, we'll post it on the web later what we <u>think</u> is the law <u>now</u>, BUT
d) please stress the possibility of change through statute or case law. In our view, a professional should do what s/he thinks right but be able to justify it in writing. If the justification is sound, a professional is unlikely to get into major legal trouble, may even improve the law!

<u>Ground rules for ethics in small subgroups</u>

- The groups must be of mixed professionals.
- Each student should speak and take turns to do so.
- Students give reasons as to why they should do what they plan to do.
- Students state the assumptions they are making.
- Process is as important as outcome.
- Final action should delineate roles and responsibilities.

In order to encourage students to discuss openly within the sub-group, it is important that it is stated by a facilitator at the beginning that whatever is said in the session is treated with respect and regarded as potentially confidential if the participant so wishes.

Learning through case studies

The following elements should be considered when preparing a response to case studies in healthcare ethics and law.

1. Summarise the case study.
2. State the moral dilemma(s).
3. State the assumptions being made/need to be made.
4. Analyse the dilemma(s) in terms of general ethical principles.
5. Analyse the dilemma(s) in terms of outcomes.
6. Spell out possible solutions or ways forward, giving reasons for accepting or rejecting each.
7. Note any legal implications.
8. Come to a conclusion about what to do.
9. Consider how practice could be improved/changed in light of this particular case study.

Questions to us – our e-mails and telephone numbers are:

E-mail:	Telephone no:
peter.haughton@kcl.ac.uk	020 7848 6993/4151
roger.higgs@kcl.ac.uk	020 7848 4115

We shall try to respond quickly and post our attempts at answers on the virtual campus.

GENERAL NOTES:

Confidentiality, Consent and Truth-telling

The three case studies are designed to provoke discussion in small groups. The Case Studies should help the students to begin to develop an understanding of the duties and responsibilities of health care professionals. No single case study can be comprehensive in its coverage of either a topic (e.g. euthanasia) or a concept (e.g. Confidentiality). The material we offer has been selected as a means to helping the students engage and begin to own these important ethical health care issues.

As facilitators we are not providing our groups with right answers – indeed there may not be a right answer either from a legal or ethical perspective, rather we are creating an environment in which students can explore the problem(s). Both conflict in values and conflict over legal rights occur within the delivery of health care.

For we live in an increasingly plural society with diverse beliefs and values. Most of us have developed our view of what is ethical through the influence of our parents, our upbringing, our religious beliefs, conscience or personal philosophy and those who have taught us. Against this our health care professional associations try to define standards that the public can expect from health care professionals. Tensions between public and private morality will exist and these will emerge from the discussion of these case studies. At this stage of their learning it is important to recognize the tensions without necessarily reaching a consensus of what is right or best. The expectations of health care professionals may differ from the privately held views of members of the group.

Some additional questions that facilitators may find useful when working with this material. Reference to these issues are covered in the lectures.

<u>Confidentiality</u>:

Health Care Professional Governing Bodies play a central role in enforcing matters of health care confidentiality.

- What are the circumstances in which it may be ethically justifiable for a health care professional to breach confidentiality?
- How could the concept of confidentiality conflict with any other ethical concepts/values/principles?
- Why do people place such a high value on confidentiality?

Consent:

- Why is the concept of informed consent so important in the delivery of health care?
- In what ways is our autonomy limited?
- Should the autonomy of a health care professional be respected as well as that of the patient?
- Are there ever justifications for over-riding a patient's refusal to give consent?

Profound changes in public attitudes during the last decade have had a very significant effect on the manner in which consent to health care treatment must now be obtained. What was once almost universally accepted practice today may be considered unethical by Health Care Professional Governing Bodies and unlawful by the courts.

Truth–telling:

It is assumed that health care professionals will be truthful to their patients/clients. Failing to tell the truth will have inevitable consequences for the health carer / patient relationship. Truth-telling, like informed consent, indicates a respect for the patient and their autonomy. But if patients have a right to expect the truth from those caring for their health, do health care professionals have a right to expect their patients to tell the truth?

- If you found that your health carer had lied to you about the risks and benefits of a particular procedure, how would you feel and respond?
- Would the benefit of a successful outcome to the procedure outweigh the harm of the health professional's deliberately misleading you, the patient?
- Does the end ever justify the means used in the delivery of health care?
- Is there ever a justification for not telling the truth to patients?

(The above notes are modifications of Medical *Consent and Confidentiality for undergraduates and House Officers* © The MDU 1997)

SESSION 3 : ETHICS CONFIDENTIALITY LECTURE

There are three lectures and two discussion seminars sessions following the second two lectures. The **lectures** are:

1. Confidentiality (IPE Session 3)
2. Consent (IPE Session 5)
3. Autonomy, paternalism and truth-telling (IPE Session 7)

THE DISCUSSION PROCESS

1. **Overall aims**
   - students should own the concepts
   - students should be able to articulate the concepts
   - students should be able to reflect on/discuss the concepts
   - students should be able to apply the concepts

2. The aims and objectives of the lecture, as stated in the students' pack is:

IPE Session 3 – Ethics: Confidentiality lecture

(There is no tutorial after this lecture).

At the end of the session, the student will be able to:

- State the duty of confidentiality owed to the patient by the healthcare worker or a student in training
- Illustrate the difficulties inherent in clinical practice and education with respect to confidentiality
- Justify the exceptions allowed or required in UK health care practice with respect to confidentiality

Formulate simple ways of proceeding in clinical practice to balance confidentiality with safety for patients.

Please allow 5mins at the end of the session for the students to fill out their session evaluation form and collect from them before they leave. Please return completed forms to Caroline Tompsett in Room G4, Ground floor, Clinical Skills Centre.

SESSION 5 : ETHICS 1

THE TUTORIAL PROCESS

1. **Overall aims for Ethics Sessions 5 and 7**
   - students should own the concepts
   - students should be able to articulate the concepts
   - students should be able to reflect on/discuss the concepts
   - students should be able to apply the concepts

2. The aims and objectives of the lecture, as stated in the students' pack are:

IPE Session 5 – Ethics 1 : Consent

At the end of the session, the student will be able to:

- ➢ Define clinical consent, understand why it is required, and name the different types
- ➢ Explain the right to consent and how it is used in clinical practice
- ➢ Demonstrate how to obtain consent in general terms
- ➢ Define competence and capacity
- ➢ Identify the particular problems of children and adults with impaired ability
- ➢ Demonstrate how the concepts of respect for autonomy, duty and utility underpin the need for consent
- ➢ In the area of consent contrast the different requirements of ethics, law and clinical practice
- ➢ Demonstrate ethical and legal reasoning in case discussion

3. The tutorial following IPE Session 5 lecture on consent covers both consent and confidentiality.

4. IPE Session 5 tutorial has a rolling discussion of a case broken into 3 parts of 10 minutes each: "The sick colleague" – see page 36 for flowchart. Acetates will be provided for tutors and paper copies will be provided for students.

Case Study A for use in Session IPE SESSION 5 – ETHICS 1

between 15th October and 19th November.

IPE Session 5 "The Sick Colleague"

Case A

Stage 1 (10 minutes)

During a late night drinking session, a fellow student who has been your best friend on the course so far, confesses to you that he is 'probably' HIV +ve. He says he feels he ought to tell his sexual partner (another of your student colleagues), but doesn't think he can bring himself to do so.

- What would you do now and why?

Stage 2 (10 minutes)

When you next see your friend a few days later he reveals that last night he and his partner got drunk at a party and had unprotected sex when they got home. He still hasn't told his partner about his HIV suspicions.

- What would you do now and why?

Stage 3 (10 minutes)

He starts talking about his next stage of training, which has close patient contact. He is now anxious about the prospect of this part of the course. He is not specific about the precise nature of his concerns.

- What would you do now and why?

At each stage of the case, students should indicate what action they think appropriate, together with the reasoning that supports their decision.

<u>Overall rolling case student agenda</u> (for feedback)

- What are the problems?
- Whose are the problems?
- What would you (as an individual) do?
- Why?
- What does the group agree about?
- What does the group disagree about?
- How could a team resolve these disagreements?
- What assumptions have been made by the group?

Additional issues which you may wish to raise with the students if time permits:

<u>Stage 1.</u>

Potential Medical Problem – HIV status: Source of infection; infection control

Potential moral problem of who has a right to know this information.

Who has a duty of care in this situation? Does the duty of care extend beyond your friend? How far?

Assumptions: - Is the partner male or female and does it make any difference?

<u>Stage 2.</u>

If someone is drunk, can they give valid consent for sex?

Questions in Stage 1 above still have relevance.

<u>Stage 3.</u>

If he now knows his HIV status (and it is +ve). Do we think this is different from just 'not knowing'?

Does King's College London have any responsibility in all this? (Assuming that this is a King's Student!) What about other agencies?

SESSION 7 : ETHICS 2

THE TUTORIAL PROCESS

1. **Overall aims for Ethics Sessions 5 and 7**
   - students should own the concepts
   - students should be able to articulate the concepts
   - students should be able to reflect on/discuss the concepts
   - students should be able to apply the concepts

2. The aims and objectives of the lecture, as stated in the students' pack are:

IPE Session 7 – Ethics 2: Autonomy, Truth-telling and Paternalism

At the end of the session, the student will be able to:

- ➢ Recall the requirements of confidentiality and consent
- ➢ Define autonomy, paternalism and their appropriate application
- ➢ Explain the moral and legal background to respecting a person's autonomy and recognize the link with human rights.
- ➢ Contrast this with the duty of care, to avoid harm and to provide a just and equitable response in health care
- ➢ Demonstrate the difficulties raised by the duty to telling the truth in healthcare, and begin to identify ways in which this can be resolved in practice
- ➢ Discuss the use and misuse of power in the clinical context

3. The tutorial following IPE Session 5 covered consent and confidentiality and this tutorial visits both of these in addition to autonomy, truth-telling and paternalism.

4. IPE7 (autonomy, paternalism and truth-telling with revision of confidentiality and consent) has 2 single case studies that take 15 minutes each: "Slim chances" and "Uncle". Special questions are attached to each, although IPE Session 5's objectives also apply. Acetates will be provided for tutors and paper copies will be provided for students.

Case Study B for use in Session IPE SESSION 7 - ETHICS 2

between 14th January and 18th February

IPE Session 7 "Slim Chances" (15 minutes)

Case B

You make friends with Helen in your first year at GKT School. She looks very thin and you notice she avoids doing things which involve eating in company. One day, you discover her making herself vomit in her room. She refused to discuss it, and as the term progresses her behaviour becomes more and more secretive. She seems to be avoiding lectures and social events, staying in her room most of the time.
You are concerned for her health and well-being and raise your concerns with her. When you do this, she swears you to secrecy and explains that as far as she is concerned she is overweight, she feels fat and people don't like her. Sometimes they whisper behind her back and she feels she must continue to lose weight. You cannot convince her otherwise.

- What should you do and why?
- Should you break her trust and tell someone about her behaviour?
- Would it be appropriate to force her to have treatment?
- Is Helen's medical problem your problem?
- What is your duty of care and what is its nature?
- How would you feel if Helen's takes her life?
- Does King's have any responsibility towards Helen, and if so, what?
- What if it is not anorexia, but Helen is pregnant or has a wasting disease?

Case Study C for use in Session IPE SESSION 7 - ETHICS 2

between 14th January and 18th February

IPE Session 7 "Uncle" (15 minutes)

Case C

During your last holiday you find that your next door neighbour has just been taken to hospital. He is an elderly man who you have known as "Uncle" all your life. He has very little English, and was a political refugee: he was in an ethnic cleansing camp before he and his family managed to get to the UK. He does not trust people easily: you are his favourite person outside his very close family.

You visit the hospital to enquire how he is: in order to get the nurse in charge to tell you about him, you say he is your grandfather. The nurse tells you "your grandfather" is recovering from a severe chest infection, but as part of a routine series of tests they have found he has tuberculosis (TB). He will not speak to the health care team but lies huddled up in bed. They don't know what to do as he needs treatment for this disease. The nurse asks you to help, as a member of the family.

- Should the team treat him without his informed consent?
- Should you help the team?
- What, if anything, should you tell "Uncle's" family?
- Is your deception (posing as a relative) justifiable?
- Who needs to know about "Uncle's" T.B.?
- Does "Uncle" have a right not to know?
- Has the Charge Nurse broken patient confidentiality?
- Would it make any difference if you had presented yourself not only as a relative but also as a health care professional (in training)?
- How competent is "Uncle"?

The above questions are not exhaustive, but may be used to stimulate further thoughts and discussion either in the small groups themselves or at the closing plenary.

SESSION 6 : WRITTEN HEALTH INFORMATION

INTRODUCTION

It is common to find health information leaflets in a wide range of health care contexts. Patients also access healthcare information from other resources including the media and the internet.

During this session you will be expected, in groups, to critically appraise a small selection of written information leaflets and materials targeted at patient/client groups. You will be asked to critique the literature and present any recommendations your group may have.

THE TASK

As part of your IPE course you will work together on selected material in small mixed groups of health professional students. Your group will present your work to the main group.

Points to focus on are:

- Accessibility of language
- What is the main message in the leaflet?
- How patient centred is it?
- Do you think it meets information needs of the readers?
- What ideas or recommendations or approach do you have in regard to the subject matter?

MAIN AIMS OF THE SESSION

To draw on existing communication skills

To apply skills to written patient communication/information needs.

To work together in a team using a problem based approach

To critique written health information material with the readers information needs in mind

LEARNING OBJECTIVES

By the end of this session students will have:

- Identified effective ways of sharing ideas and information.
- Demonstrated effective ways of problem solving within a group.
- Demonstrated positive and respectful attitudes to colleagues' contribution to a task.
- Presented their groups work reflecting the views

PATIENT-CENTRED INTERVIEW SKILLS GUIDE

OPENING: ESTABLISHING RAPPORT

- **Greeting and introductions**

Verbal and non-verbal message: facial expression, tone of voice, shake hands if appropriate.

- **Attention to comfort and privacy**

Environment, seating and positioning. Allows patient time to sit down or change position if necessary. Consider individual's accompanying or visiting patients.

- **Awareness of cues that might indicate emotional state of patient**

Verbal cues: tone, pitch and pace of speech. Non-verbal cues: facial expression, body position and tone, hand movements.

- **Checks with the patient for their understanding and purpose of the interview**

Invites the patient to speak. Starts with open questions.

EXPLORATION: MANAGING TIME AND CONTENT CONVEYING EMPATHY VERBALLY AND NON VERBALLY

- **Surveys problems and concerns**

Asks, *'Is there anything else'* e.g: *'what other problems would you like to mention?'* or *'Tell me about anything else which might be worrying you?'.* Uses appropriate eye contact, body posture, nodding and encouraging gestures. Reflects back verbally and matches patient's language.

- **Negotiates priorities for problems**

Determines jointly with the patient which problems to focus on.

- **Appropriate question style (generally moves from open to closed as interview progresses)**

Avoids interrogative style of interviewing. Listens attentively to patient's responses to each question, acknowledges patient's responses. Appropriate use of silence to allow patient to process thoughts and feelings. Allows time to answer.

- **Explores and responds to patient's ideas, concerns and expectations (I.C.E.)**

Uses empathic responses to reflect and legitimate patients concerns. Uses statements *like 'It is understandable that you feel this way about…'/ 'That must have been difficult for you'.* Remains respectful and non-judgmental.

- **Uses language the patient understands**

Matches language and avoids use of unexplained medical jargon.

- **Checks for meaning and understanding, clarifies unclear statements (from both Doctor & Patient perspectives)**

Uses phrases like, *'Can you tell me what you mean by../ understand about../ expect to happen...'. And 'Let me just try to understand this a little better/ can I just check with you...?'.*

- **Focuses and re-directs the patient appropriately**

Uses phrases like *'You mentioned X earlier on, can you tell me a little more about that?'* Moves on to using more closed questions.

- **Summarises content, feelings**

Employ's reflection, e.g.*: 'You seem particularly worried by this'* or *'You look upset'.* Uses statements like: *'Can I just go over what we have discussed so far'* or *'let me just go over what we have talked about so that I can be sure I fully understand how this affects you'.*

CLOSING

- **Negotiates a final summary with patient**

Offers a summary statement. Confirms what will happen next.

- **Agrees course of action with patient**

Checks for understanding. Checks emotional state of patient. Asks if patient is OK before he/she leaves patient.

- **Closes interview, says goodbye**

Shakes hands if appropriate.

IPE Year 1 – Communication Skills Assessment

REFLECTIVE ACCOUNT OF PATIENT INTERVIEW MARK SHEET

Part 1: Communication skills

Through his/her writing the candidate has:

- Demonstrated understanding of the purpose of the interview [1]
- Given examples of communication skills used (1 mark for each skill – listening, rapport, empathy, question styles. Maximum of 3 marks) [1] [2] [3]
- Noted the effect communication skills had on the interview process (on self, patient or partner) [1] [2] [3]
- Reflected on thoughts or feelings of self, patient or partner [1] [2] [3]
- Reflected on feedback from partner and/or patient [1] [2] [3]
- Reflected on learning [1] [2]
- Reflected on relevance for future practice [1] [2] [3]

Part 2: Professional skills

Standard of written English to include:

- Reasonable sentence structure [1]
- Evidence of planning and logical development in writing [1] [2]
- Good paragraph layout, use of bold type, underlining, headings, use of graphics [1] [2]
- Correct spelling [1]
- Presentation of document in plastic wallet or folder [1]

Part 1 = 18 (min. comp = 11)
Part 2 = 7 (min. comp. = 5)

Total possible score = 25

References:

General

Website for the UK centre for the advancement of interprofessional education : www.caipe.org.uk

Website for the Learning and Teaching support network (students can access the next two publications : www.health.ltsn.ac.uk

Reading

Barr H (2002) Interprofessional education today, yesterday and tomorrow LTSN:London

Freeth D et al (2002) A critical review of evaluations of interprofessional education LTSN:London

Hind M et al (2003) Interprofessional perceptions of health care students Journal of Interprofessional Care 17,1,21-34

Zwarenstein, M et al (2000) Interprofessional education : effects on professional practice and health care outcomes (Cochrane review). The Cochrane Library. Issue no. 4. Oxford : Update Software

Medicine

Website for the General Medical Council: www.gmc-uk.org

Duties of a Doctor:
www.gmc-uk.org/standards/default.htm – will take you to the GMC's Ethical Guidance page. Click on the "More about guidance" drop down menu and then select "Guidance on good practice" – you will find Duties of a Doctor here.

Dentistry

Website for The British Dental Association: www.bda-dentistry.org.uk
Providing links to the Information Centre and Good Practice

Website for The General Dental Council: www.gdc-uk.org

Nursing & Midwifery

Website for the Nursing & Midwifery Council containing Professional Conduct: www.nmc-uk.org/cms/content/Publications

Pharmacy

Links to professional bodies
www.rpsgb.org.uk
www.pharmj.com

Health Promotion leaflets
www.rpsgb.org.uk/pdfs/leaflet.pdf
www.hpe.org.uk/leaflettest.htm
www.hpsa.org.uk/resources/effectiveness/leaflets.htm

Physiotherapy
Website for Chartered Society of Physiotherapy containing Rules of Professional Conduct (available to general public): www.csp.org.uk
Student Membership Number gains access to further resources

Dietetics
Website for The British Dietetic Association (BDA): www.bda.uk.com/index.html

Website for the BDA professional standards: www.bda.uk.com/ProfStandards.html

Website for BDA good practice in consent: www.bda.uk.com/statements.html

Website for BDA Ethical & Professional Advisory Panel: www.bda.uk.com/epap.html

Health Professions Council (HPC) statement of conduct for Dietitians: www.hpc-org/publications/standards/Standards_of_Proficiency_Dietiticans.pdf

Reading
Gable J (1997) Counselling skills for dietitians. Blackwell

MBBS SESSION 3: INTRODUCTION TO ROLE PLAY

TUTORS NOTES

The main aims of this two hour session are:

- To further develop students relationship skills in medical interviewing
- To introduce students to role play as a learning method for communication in healthcare
- To introduce shared decision-making and collaborative approaches when working with patients.

LEARNING OBJECTIVES

On completion of this session students should be able to:

- List the components of effective feedback for communication skills learning
- Agree with their group members rules and guidelines for acceptable attitudes and behaviours in role play sessions
- Participate in role play activity and feedback
- Demonstrate appropriate empathic responses within a role play scenario.

STRUCTURE OF THE SESSION

This is a two hour session comprising of:

- 1 hour role play.
- 1 hour directed reading and learning.

Role Play:

- Divide students into 3 sub-groups for role play practise [see pages 19-22 for role play scenarios].
- In each of the sub-groups you will need a student volunteer to play the part of the patient and another to play the part of the medical student carrying out the interview. The student playing the part of the patient can keep their own personal characteristics whilst adopting one of the health problems outlined in the scenarios.
- Each sub-group has 30 minutes to complete two role play scenarios with feedback.

- Allow 10 minutes to debrief students, summarise and conclude at the end of the session.

While half the students are in the role play session, the other half will be given the Student Information Pack & Worksheets. The student groups will then swap round.

(Directed reading: *'Primary care: core values of patient centred primary care'*. Toup, L; BMJ 1998; 316:1882-1886)

ORGANISATION OF ROLE PLAY

Each role play session consists of 3 scenarios. There must be *10 minutes* allowed at the end of the sessions for summarising and debriefing.

LEARNING OBJECTIVES

By the end of the session students will have had the opportunity to build on clinical experience and previous communication skills learning and should be further able to:

- List common barriers to effective communication in dealing with critical and / or difficult situations from both patient and health professional perspective.
- Demonstrate verbal and non-verbal communication skills, which help to build and maintain rapport and empathy with patients and others.
- Demonstrate an ability to provide emotional support for patients or others and create an atmosphere of respect and trust.
- Identify patients concerns and communication needs
- Deal effectively and sensitively with patient's questions and concerns, give relevant information in language patients or others understand and checking for such understanding.
- Demonstrate effective information gathering and explaining skills by the use of appropriate questions styles, reflection, checking, clarification and summarising.
- Demonstrate ability in managing an interview from introduction to closure; agree with the patient, or other, the purpose of the interview and reach consensus with the patient or other as to what happens next.
- Reflect on their own learning, personal and professional development and their own reactions to others through giving and receiving feedback.

GUIDELINES FOR ROLE PLAY

It is common for students to feel levels of anxiety and uncertainty about what is going to happen in role play sessions. It is also common for tutors to feel likewise. However the tutors have a responsibility to welcome the students and develop a rapport with the group. If a supportive trusting atmosphere can be created then this will help and encourage the students to get as much as they personally can out of the sessions.

Some suggestions on how to do this:

If the group is meeting for the first time it is worth spending a few minutes on introductions.

Find out if any of the group have taken part in role play sessions before.

a) They may like to comment on their experience.

b) Find out about their beliefs and views with regard to role play.

c) Describe in simple terms what is going to happen during the session.

Describe role play as an opportunity to practise skills. Role play is not about performing. We use role play to learn and practice communication skills in much the same way as we practice other clinical skills to become more effective or proficient. What are initially perceived as mistakes often turn out to be the most interesting and rich learning opportunities for everyone [including tutors].

Agree on ground rules for the sessions. These might include:

- Confidentiality
- Not laughing *at* others [laughing *with* each other is of course OK]
- Listen to one another
- Don't be afraid to speak
- Be honest
- Respect each other's feelings

If anyone is unsure of worried about anything in sessions then they are encouraged to meet with the tutor to discuss it. If for any reason students cannot attend or miss a session they are expected to contact the tutor. ALL STUDENTS ARE EXPECTED TO ATTEND.

COMMON RESPONSES TO ROLE PLAY

Two of the most common responses from students during role play sessions are:

a) Role play is acting therefore not realistic

It is usually helpful to agree with those who object to role play on the grounds that it is a contrived situation. Any anxieties that they may have ought to be legitimated. After this it is important to reinforce what the *purpose* of role play is.

> *"Role play is useful in helping us to focus and reflect on specific communication issues and processes. It provides an opportunity to practice communication skills which will prove invaluable for you in your contact with patients and others in the future."*

b) Disruptive or displacement behaviour

Joking and intellectualising are common avoidance or displacement behaviours. A skillful facilitator will integrate humour and discussion into the role play. It may be necessary to steer and focus the group back to the purpose of the session so as not to lose sight of what the session is really for. It one of the members of the group is particularly 'difficult' then the facilitator will need to have the skills to manage the challenge in a non-defensive way. Sometimes it helps to ask the rest of the group for their opinion. This allows time for the facilitator to formulate how to answer and behave towards the challenge. It also tends to have the effect of making the problem a shared one and not the facilitator's alone.

INDIVIDUAL 'SAFETY' AND LEARNING NEEDS

A friendly 'safe' atmosphere must be established to ensure that students feel comfortable enough to try out skills in role play. If individuals feel threatened they are unlikely to learn and will not feel confident. They may become defensive or disruptive.

Taking 'time out' is a very important process in role play. This is where students who have 'got stuck' or want to discuss choices for their next move can turn to the group for input. This has a dual function of a learning opportunity and of changing what was initially the student's individual difficulty into a shared group problem.

Feedback is an integral part of role play and needs to be handled carefully. [see guidelines for feedback].

Ensure adequate debriefing at the end of role play or any communication skills exercises. Re-orient the students into their own selves, present time, space and situation.

Do remember that interactive sessions such as these can trigger off personal responses in individuals because of events or experiences in their own lives. Take care when encouraging reluctant individuals to actively participate. Sensitivity is needed with some reluctant participants, it may be that they feel emotionally vulnerable - not just refusing to take part because they think it is rubbish.

PRACTICAL POINTS

Allow enough time to set up the role play. This means:

- checking that everyone knows what is expected of them
- explaining what activity they are going to be doing
- identifying what processes are going to be concentrated on
- clarifying what the context and content of the role play is
- attending to the physical environment - space, seating, observation points
- allowing enough time for feedback

GUIDELINES FOR FEEDBACK

The purpose of feedback is:

- to give the individual information to help them recognise what they have done effectively
- to suggest ways of doing, or thinking about, something differently in order to be more effective in the future
- to help them to identify learning and personal development needs

WHAT & HOW OF FEEDBACK

Feedback is not the same as criticism. Feedback is necessary in the processes of teaching and learning. Feedback is a skill and involves informing another of your observations of his or her behaviour. It is not about commenting on an individual's persona or identity. Feedback should be concentrated on what somebody has actually done behaviourally.

1. Allow the student to talk first and offer a self-critique.

2. Focus on the positive first and use descriptive terms.

3. There may be a difference in the intention of an individual and their behaviour. In other words we may intend to achieve something, but our behaviour does not meet the original intention. It is useful to separate behaviour from intention.

4. All feedback is subjective. Always make your comments in the first person. The person receiving it may disagree.

5. Individuals can only take in a few comments at a time. Keep to a few points and don't overload the content.

6. Be specific. Saying, "that was good" is not enough. What specifically was good, what did the student do, how did he/she do it? What was the effect of the good communications?

ORDER OF FEEDBACK

LEARNER (Doctor)

↓

ACTOR (Patient)

↓

COLLEAGUES /GROUP

↓

FACILITATOR

(Facilitator may participate to add any outstanding points, checking for learning and summarising.)

ROLE PLAY 1

Student task

You are on General Practice attachment and have been asked to see this patient to find out what their main problems are. Try to apply the communication skills we have covered so far in the sessions.

Patient profile

You are to be yourself, but imagine you have the following health problem.

You have suffered with migraine in the past but since starting medical school they have become more frequent and severe. You have to have a whole day off from college and feel washed out for a couple of days after each attack. This is interfering with college and social activities. It is also difficult to get peace and quiet in student accommodation and you are quite fed up. If the medical student is sensitive and encourages you to talk about the migraine, how the symptoms effect your everyday life, and what you are most worried about, then do so.

Signs and symptoms

Severe right-sided headache, sensitivity to light and noise. Nausea with occasional vomiting during some of the attacks. You feel tired and washed out for a couple of days after each attack. You have to lie down during an attack.

What have you done to help so far?

You have tried migraleve but only offers a small amount of relief.

Main ideas, concerns and expectations [ICE]

Increasing frequency of attacks and failure to respond to migraleve have made you begin to wonder if this is something even more serious than migraine. You are worried about missing time from your course. You are feeling a bit miserable about the whole thing. You hope that the doctor will be able to offer effective treatment and refer you to a specialist if necessary.

ROLE PLAY 2

Student task

You are on General Practice attachment and have been asked to see this patient to find out what their main problems are. Try to apply the communication skills we have covered so far in the sessions.

Patient profile

You are to be yourself, but imagine you have the following health problem.

You have a painful swollen wrist. You are a member of a squash club and you have a tournament coming up and your wrist has become painful and swollen. You are anxious that if it gets worse you will not be able to compete in the tournament. If the student is sensitive and encourages you to talk about how this is a problem for you then do so.

Signs and symptoms

Painful, swollen wrist. Getting worse over the last 3 days.

What have you done to help so far?

Taken paracetamol for pain and have been wearing a wrist support when playing squash.

Main ideas, concerns and expectations [ICE]

The tournament is getting closer and your wrist is getting worse. You really want to do well in the match and the way things are at the moment you are not going to be able to play well, if at all. Can the doctor do something to help in time for the tournament? You have to complete a written assignment for college and you are finding it difficult to write or type. You are not sure whether to ask for a medical certificate to send in for mitigating circumstances for an extension.

ROLE PLAY 3

Student task

You are on General Practice attachment and have been asked to see this patient to find out what their main problems are. Try to apply the communication skills we have covered so far in the sessions.

Patient profile

You are to be yourself, but imagine you have the following health problem. You have had discomfort in your lower back for a few days and have not been feeling very well. Since yesterday morning you have experienced a burning sensation when you pass urine and also feel a bit feverish.

Signs and symptoms

Increasing discomfort in your lower back, a burning sensation when you pass urine, generally feeling off colour, a bit shivery and feverish.

What have you done to help so far?

You have taken paracetamol and tried to drink a lot of fluids. You have been going to bed early to try and rest.

Main ideas, concerns and expectations [ICE]

At first you thought that you had somehow strained your back but are now worried that you have got some sort of urinary infection. You are particularly worried that this might have affected your kidneys because of the backpain you have been having. You are finding your coursework quite hard going and are worried about having to take any time off. You are hoping that the doctor will be able to give you treatment to clear it up promptly and for some reassurance that you don't have anything seriously wrong with your kidneys.

ROLE PLAY 4

Student task

You are on General Practice attachment and have been asked to see this patient to find out what their main problems are. Try to apply the communication skills we have covered so far in the sessions.

Patient profile

You are to be yourself, but imagine you have the following health problem. You have had a sore throat on and off for a few weeks and have also been feeling extremely tired. You were hoping this would clear up if you looked after yourself and had a bit more rest, but you have now found out that your ex-girl/boyfriend (who you split up with three weeks ago) has been diagnosed with glandular fever. You are now worried that this is what's wrong with you.

Signs and symptoms

Recurring sore throat with slightly swollen glands at the side of your neck. Very tired and feeling run down.

What have you done to help so far?

You have tried various throat lozenges and taken paracetamol with little effect. You have been socializing less and going to bed early.

Main ideas, concerns and expectations [ICE]

You are worried that you have caught glandular fever from your boy/girlfriend. You know that this can make you feel very ill and it can take a long time to recover. You really do not want to miss out on any more of your social life and are also concerned it might affect your studies as you have exams coming up shortly. You are hoping the doctor will say you haven't got glandular fever and can give you some antibiotics to clear up your sore throat.

MBBS SESSION 4: MANAGING THE MEDICAL INTERVIEW

The aim of this session is to give students the opportunity to manage a basic medical interview using a structured approach (i.e. demonstrate an opening, exploratory and closing phase to the interview). ****Students need to bring the medical interview communication skills guide to this session.***

Teaching and learning methods: small group role play; structured self-directed learning and video demonstration.

Learning objectives

On completion of this session students should be able to:

- Demonstrate effective ways of managing information in predetermined time including the following:
    - How to begin the interview and establish rapport
    - How to explore the patients problems and demonstrate empathic responses
    - How to clarify and focus on main concerns
    - How to reflect and summarise information gathered
    - How to close the interview

Structure of Session: 1 hour session:

10 minutes introduction and set up of session.

3 x 15 minute role plays (5 mins role play with 10 minutes for feedback).

5 minutes to summarise and close

(Whilst half the students are in the role play session, the other half will watch a video demonstration of a patient interview and be given directed reading. The student groups will then swap around).

Directed reading: 'Framework for teaching and learning informed shared decision-making' Towle A, Godolphin W; BMJ 1999; 319:766-771.

ROLE PLAY SCENARIOS

Purpose of role play:

To explore a patients problem using the framework of the Medical Interview Skills Guide (students to demonstrate opening, exploratory and closure phase of interview).

The role play is set in General Practice. The student is to see the patient prior to their appointment with the GP. Each role play to last six minutes.

The focus of the feedback to students is on their communication skills, *not about accuracy of clinical details.*

Student instruction:

You are on placement in General Practice. You have been asked by the GP to see this patient prior to their appointment. Your task is to explore the patient's problem and how it is affecting them. [Try to use the structure of the Medical Interview Skills Guide, with an opening, exploratory and closing phase to the interview].

Instructions for role players:

[The scenarios can be adapted to the role players own characteristics (age, gender and personality traits), but remember that these are very junior students so information should be given reasonably freely and without any 'difficult' behaviours].

Scenario 1:

You have a bad back following a long period of gardening two days ago. You can't bend or lift today and the pain seems to be getting worse. You have taken a few doses of paracetamol, which helped a bit.

Job = carpet fitter or school cook. Or retired. Off work today /or if retired not helping with 2yr old grandson due to bad back. Have come to dr. for advice and hopefully treatment.

Scenario 2:

You have a persistent cough following a cold for 2 weeks. It seems to be getting worse. You are now coughing up yellow / green phlegm. Your chest is getting sore and your stomach muscles hurt from coughing. It's worse at night.

Job = University librarian. Cough is very troublesome at work. You're due to do a rota in the study area in a couple of days where there is supposed to be strict silence. You are hoping the doctor will be able to give you something to cure the cough and relieve your symptoms.

Scenario 3:

You have been suffering from indigestion /heartburn for a couple of months. It is worse at night. You can't lie flat because it aggravates it and it is disrupting your sleep. You have taken some Rennies and they do help a bit.

Job = Sales rep. It involves a fair amount of corporate entertaining and you eat irregularly. You and a group of friends call your selves the 'curry club' because you love a curry on Friday night. You want the doctor to give you some medicine /tablets to take away the discomfort so you can get on with your normal routine.

YEAR 2
MBBS SESSION 1: DEVELOPING THE MEDICAL INTERVIEW: EXPLORING & EXPLAINING SKILLS

The aim of this session is to develop student's skills in exploring a patient's problem and explaining a medical condition or procedure.

Teaching and learning methods: role play in small groups & directed reading

Learning objectives:

On completion of this session students will have:

- Revised basic communication skills and structure of a generic medical interview
- Practised skills required to explore a patients problems
- Practised explaining a simple diagnosis, treatment or procedure to a patient

Structure of Session:

One hour session - 10mins set up (Learning objectives, outline of scenarios)

3 x 6 minute role plays each with 10 minutes feedback. As there are two scenarios for the session, the third student will be repeating a scenario. This provides an opportunity for the group to be exposed to contrasting communication skills styles.

While half the students are in the role play session, the other half will be given the *'Year 2 MBBS Communication in Healthcare Information Pack & Worksheets'* and directed reading. After one hour, the student groups will swap around.

Directed reading: ***'A model of empathic communication in the medical interview'***; Suchman et al; Journal of the American Medical Assoc; 1997, Vol 277:8:678

'Patients unvoiced agendas in GP consultation'; Barry et al; British Medical Journal; 2000, Vol 320: 1246

DEVELOPING THE MEDICAL INTERVIEW:

Role Play 1: Exploring (diabetes).

Female - 60's retired music teacher.

You have recently been diagnosed with late onset (type 2) diabetes. Your GP explained about diabetes to you on your last visit a couple of weeks ago and advised you about managing your blood sugar levels through altering your diet. You are trying your best to do this, but have a number of concerns and worries that you have not yet asked about. You have come back to the see your GP about these. The GP has asked you to see the medical student first and you have agreed.

You will start by telling the student about your recent diagnosis. You will appear rather worried. Hopefully the student will encourage you to express any concerns you may have verbally and non-verbally. Given any encouragement you will disclose that you are concerned about the following:

- What will happen if you cannot control your blood sugar by altering your diet (you are very nervous about injections and you know that some diabetics have to inject themselves – you don't want to have to do that).
- Whether you will end up having complications because of your diabetes. A friend of yours who is diabetic recently had two toes amputated. She told you that this was because the diabetes had affected her circulation. (If the student asks – your friend is a smoker, is insulin dependent and has had diabetes for many years).

Student instruction:

You are a year 2 medical student in General Practice. You have been asked to see this patient who has recently been diagnosed with late-onset diabetes. Your task is to explore why she has come to see the doctor and respond to her concerns.

DEVELOPING THE MEDICAL INTERVIEW:

Role play 2: Explaining (asthma)

Male /Female, 20's – 30's)

You have recently been diagnosed with asthma. You have developed a wheeze and have been coughing, particularly on exertion over the past few months. When you came to see your GP a couple of weeks ago she was away and you saw a locum. The locum told you that you had asthma and told you a bit about it, but didn't take it all in at the time. He also gave you a blue inhaler to use for when your chest feels tight or you become wheezy, but you are not really sure how this works. You either play a sport or like jogging and you are worried about whether you should carry on with it.

You have come back to see your regular GP to get further information.
You have agreed to see a medical student prior to your appointment with the GP. The student will try to answer your questions and give you further explanation of your condition.

You will ask the student:

- To tell you more about what asthma is and what causes your symptoms.
- How does the inhaler that you have been given work?
- Whether it is possible for you to continue with your sport/jogging and if you should take any precautions?

Student Instruction:

You are on placement in General Practice. Your GP has asked you to see this patient who has recently been diagnosed with asthma. The patient wants more information about his condition and treatment

COMMUNICATION IN HEALTHCARE

2003-04

MB BS Year 1
Student Pack & Worksheets

Listening, Rapport & Empathy, Shared Decision Making and Feedback

RELATIONSHIP SKILLS

The relationship skills needed in effective medical consultations have been introduced to you. Now you need to consider these skills in more depth and be familiar with research and the evidence base, which supports the integration of relationship skills in interviews

- Rapport
- Patient centred approach
- Empathy
- Shared decision making
- Feedback

RAPPORT IS:

A term, which encompasses the concept of feeling comfortable with another person. Such phrases as: *'we just seemed to click - she was on the same wavelength as me - I felt at ease'*, describe a sense of rapport between two people. Rapport is essentially identification of similarities between individuals. The messages of similarities may be subconscious, verbal and non-verbal. *Specific skills*: - establishing, acceptance, maintaining.

(Ref: Silverman et al, *Skills for Communicating with Patients*, P.20-22, 85-86)

Exercise 1

Describe how you would go about establishing rapport with a patient you meet for the first time.

A PATIENT-CENTRED APPROACH IS:

A collaborative partnership between the patient and doctor. It is a move away from traditional paternalism towards mutuality. A patient-centred approach is more likely to allow for shared decision making. *Specific skills*: - eliciting ideas, concerns, expectations, checking for understanding

Essential Reading: *Primary Care: Core Values - Patient centred Primary Care, Toup, L;* BMJ, 1998 316:1882-6

EMPATHY IS:

1). The understanding and sensitive appreciation of another person's predicament or feelings.

and

2). The communication of that understanding back to the patient in a supportive way.

[Ref: Silverman, Kurtz and Draper 1998]

Specific skills: - reflection, acknowledgement, validation

SHARED DECISION MAKING IS:

A collaborative approach in medical consultations which includes patient ideas, concerns and expectations [ICE]. Patient participation is sought and the desired level of participation is respected. Some patients wish for more involvement than others. *Specific skills*: - exploring, explaining, planning, negotiating, agreeing

Essential reading: '*Framework for teaching and learning informed shared decision making*', Towle, A. Godolphin, W; BMJ 1999;319:766-771

Exercise 2: **Patient centred interviewing and mutual decision-making:**

Mr Calvin Johnson age 24years has recently injured his knee playing football. He is a key member of his local football team. He has been having physiotherapy for 2 weeks and his physio told him it would be another 2 weeks before he can go back to training. He has come to see his doctor to 'hurry things up'. He is anxious to get back to football. He believes an injection into his knee would relieve the pain and swelling and allow him to train normally. The doctor is not keen to do this as the knee is healing well and he feels it will not be good for his knee in the long term.

Describe how you might approach this problem in a patient-centred way.

Points to consider: Exploring Calvin's ideas, concerns and expectations [using ICE]

- Demonstrating empathy
- Collaboration in the decision to inject or not to inject his knee
- Who is responsible for the decision? [link with ethics]

LISTENING

The benefits of effective listening in the medical consultation have been well-documented (see Silverman et al. 1998, p.25-32). McKay et al have identified the following 12 blocks to effective listening. Can you identify any particular traits that you have a tendency to use?

Blocks to Listening

13. **Comparing:**	e.g. 'Could I do it that well?' 'When my mother died I coped much better'.
14. **Mind reading:**	Trying to figure out what the other person is really thinking or feeling
15. **Rehearsing:**	Giving attention to the preparation and delivery of your next comment
16. **Filtering:**	Listening to some things and not to others
17. **Judging:**	Not listening to what they say, as they have already been judged
18. **Dreaming:**	Half listening while something the other person says triggers off associations of your own.
19. **Identifying**	Referring everything the own person says to your own experience
20. **Advising**	Being the great problem-solver, ready with help and suggestions. You don't have to hear more than a few sentences before you begin searching for the right advice.
21. **Sparring:**	Arguing and debating. You disagree so quickly that the other person never feels heard. You take strong stands and are very clear about your beliefs, values and preferences.
22. **Being right:**	Going to any lengths to avoid being wrong. You can't listen to feedback or take suggestions so you continue to make the same mistakes. No acknowledge areas for development, you repeat previous patterns of behaviour.
23. **Derailing**	Changing the subject suddenly. You derail the train of conversation when bored or uncomfortable or laugh it off.
24. **Placating**	e.g. 'Right…right…absolutely…I know…of course you are…. incredible ….yes….really'. You want to be nice, pleasant, supportive. You want people to like you. You half listen, probably enough to get the drift, but you don't get involved. You placate rather than tuning in. You don't examine or explore what's being said.

(Adapted from McKay, Daws and Fanning in Messages (Communication Skills), New Harbinger Publications, 1983).

Exercise 3

1. Can you identify any particular situations or interactions in which your listening has been compromised by any of these blocks?
2. Identify how each of these criteria could effect the process and outcome of a doctor-patient consultation.

FEEDBACK

You have been introduced to the concept of feedback. In teaching and learning, feedback is goal-orientated i.e. the purpose is to help an individual to achieve a specific goal. Feedback should always be supportive and enabling. Feedback may offer a different perspective or ways of thinking about or doing something differently to be more effective.

The What and How of Feedback

1) Feedback is not the same as criticism. Feedback is necessary in the processes of teaching and learning. Feedback is a skill and involves informing another of your observations of his or her behaviour. It is not about commenting on an individual's persona or identity. Feedback should be concentrated on what somebody has actually done behaviourally.
2) Allow the other person to talk first and offer a self-critique.
3) Focus on the positive aspects first and use descriptive terms.
4) There may be a difference in the intention of an individual and their behaviour. In other words we may intend to achieve something, but our behaviour does not meet the original intention. It is useful to separate behaviour from intention.
5) All feedback is subjective. Always make your comments in the first person. The person receiving it may disagree.
6) Individuals can only take in a few comments at a time. Keep to a few points and don't overload the content.
7) Be specific. Saying "that was good" is not enough. What specifically was good, what did the person do, how did he/she do it? What was the effect of their actions and communications?

Review the structure of the Patient Centred Interview Skills guide. Identify the 3 phases of the interview and familiarise yourself with the key skills associated with each phase. Use this as a framework for your observations in clinical areas.

Suggested Reading

Spiro H [1992] *'What is empathy and can it be taught?'* Annals of internal medicine:16:842-6

Platt and Keller [1994] *'Empathic Communication: A teachable and learnable skill'*. J Gen Intern Med. 9:222-6

Strull WM, Lo B, and Charles G [1984] *'Do patients want to participate in medical decision making?'* JAMA. 252:2990-4

Degner LF, Krisjanson LJ, Bowman D et al [1997] *'Information needs and decisional preferences in women with breast cancer'*. JAMA. 277:1485-92

Kaplan SH, Greenfield S and Ware JE [1989] *'Assessing the effects of physician - patient interactions on the outcomes of chronic disease'*. Med Care. 27:S110-27

Robinson, JD [2001] *'Closing medical encounters: two physician practices and their implications for the expression of patients' unstated concerns'*. Social Science and Medicine Vol 53/5: 639-656

Suchman, AL, Markakis K, Beckman HB, Frankel R, *'A Model of Empathic Communication in the Medical Interview'*, The Journal of the Americal Medical Association, 1997; 277:678-682

Silverman J, Kurtz S, Draper J (1998) *'Skills for Communicating with Patients'* Radcliff Medical Press.

COMMUNICATION IN HEALTHCARE

2003-04

MB BS Year 2
Student Pack & Worksheets

Core Communication Skills
and Explaining and Exploring

A number of core skills were introduced in year 1. These included:

RELATIONSHIP SKILLS:

- Rapport
- Patient centred approach
- Empathy
- Shared decision making
- Feedback

- **You are advised to use the Year 1 Information Pack, containing worksheets, definitions and directed reading, to revise these key skills [See appendix 7 of POM 1 Handbook for 2002-3].**

If you have mislaid the pack, you can download a copy form the Virtual Campus (use Year 1 - Communication Skills link).

NB: Examination questions for Year 2 will be based on communication skills learning from Years 1 and 2

Additional essential reading will be given to you in the 'Developing the Medical Interview' teaching session as follows:

- ***Essential Reading:*** *Primary Care: Core Values - Patient Centred Primary Care*, BMJ, 1998 316:1882-6
- ***Essential reading:*** *'Framework for teaching and learning informed shared decision making'*, Towle, A. Godolphin, W; BMJ 1999;319:766-771

- To further develop your learning about rapport, read:
  Silverman et al, Skills for Communicating with Patients, P.20-22, 85-86

- *You should also:*

Review the structure of the Patient Centred Interview Skills guide. Identify the 3 phases of the interview and familiarise yourself with the key skills associated with each phase. Use this as a framework for your observations in clinical areas.

EMPATHY IS:

1). The understanding and sensitive appreciation of another person's predicament or feelings.

and

2). The communication of that understanding back to the patient in a supportive way.

[Ref: Silverman, Kurtz and Draper 1998]

Specific skills:- reflection, acknowledgement, validation

Four Stages of Empathy in the Medical Interview (PEAR)

Potential Empathic Opportunity — Indicated by verbal or non-verbal clues from the patient e.g. tone of voice, posture, verbal reference

↓

Encouragement to continue — The doctor encourages patient to express what they feel or think by use of verbal and non verbal encouragers ('uh mm', yes', nodding, tone of voice, use of silence, reflecting).

↓

Actual Empathic Opportunity — The patient expresses what they feel or think

↓

Respond Empathically — The doctor acknowledges and validates the patients feelings or concerns.

(Adapted from Suchman et al's (1997) *'Model of Empathic Communication'*)

Exercise 2: **Facilitating a patient's expression of emotion and responding with empathy.**

The following extracts are examples from real consultations, taken from *'A Model of Empathic Communication in the Medical Interview'* (Suchman et al., 1997). Referring to the PEAR model above, complete exercise 2:

- Identify in the following extract how the doctor encourages the patient to express his feelings
- Underline the doctor's empathic statement
- What effect do you think this may have on the doctor's relationship with the patient?
- Which non-verbal communication skills might the doctor use in this scenario?

Patient:	[discussing a relative's illness] The Doctor said it was touch and go, touch…
Doctor:	Yeah
Patient:	…and go.
Doctor:	Hmmm. How have you been doing, feeling about all this?
Patient:	I mean, you know it, makes me sad but….(pause)
Doctor:	Oh, just to see her, see her suffering that long.

Missed opportunities for empathic responses:

- Identify in the following extract the missed opportunity for the doctor to make an empathic response
- What did the doctor say instead of making an empathic response and what was the effect of this?
- Give an example of an empathic response the doctor could have made.

Doctor:	Does anybody in your family have breast cancer?
Patient:	No
Doctor:	No?
Patient:	Now I just [unintelligible] after I had my hysterectomy, I was taking oestrogen, right?
Doctor:	Yes?
Patient:	You know how your breast gets real hard and everything? You know how you get sort of scared?
Doctor:	How long were you on the oestrogen?
Patient:	Oh, maybe six months

Doctor: What year…when did you have the, uh, hysterectomy?

Learning points:

- Awareness of the patient's verbal and non-verbal communication may alert the doctor to a potential empathic opportunity in the consultation
- Sensitive response to this in the form of encouragement for the patient to continue may lead to an actual empathic opportunity in the consultation
- An appropriately timed empathic response by the doctor can lead to an improved relationship with the patient, by the patient feeling understood and supported.

Essential reading: Suchman, AL, Markakis K, Beckman HB, Frankel R, *'A Model of Empathic Communication in the Medical Interview'*, The Journal of the American Medical Association, 1997; 277:678-682

EXPLAINING SKILLS

Explaining diagnosis, conditions and procedures is a central part of medical practice. Doing this as effectively as possible requires a number of specific skills. These are introduced below:

Skills for explanation:

Providing the correct amount and type of information.

Aims: to give comprehensive and appropriate information; to assess each individual patients information needs; to neither restrict or overload.

- **Chunks and checks:** gives information in assimilable chunks; checks for understanding, uses patient's response as a guide to how to proceed
- **Assesses patient's starting point:** asks for patients prior knowledge early on when giving information; discovers extent of patients wish for information
- **Asks patients what other information would be helpful:** eg aetiology, prognosis
- **Gives explanation at appropriate times:** avoids giving advice, information or reassurance prematurely

Aiding accurate recall and understanding

Aims: to make information easier for the patient to remember and understand

- **Organizes explanation:** divides into discrete sections, develops a logical sequence
- **Uses explicit categorization or signposting:** e.g. 'There are three important things that I would like to discuss'; 'Now, shall we move on to...'
- **Uses repetition and summarizing:** to reinforce information
- **Language**: uses concise, easily understood statements, avoids or explains jargon
- **Uses visual methods of conveying information:** diagrams, models, written information and instructions
- **Checks patient's understanding of information given (or plans made):** e.g. by asking patient to restate in own words; clarifies as necessary

Achieving a shared understanding: incorporating the patients perspective

Aims: to provide explanations that relate to the patients perspective of the problem; to discover the patients thoughts and feelings about the information given; to encourage an interaction rather than one-way transmission

- **Relates explanations to patients illness framework:** to previously elicited ideas, concerns and expectations
- **Provides opportunities and encourages patient to contribute:** to ask questions, seek clarification or express doubts; responds appropriately
- **Picks up verbal and non-verbal cues:** eg patients need to contribute information or ask questions, information overload; distress
- **Elicits patients beliefs, reactions and feelings:** re information given, terms used; acknowledges and addresses where necessary

[adapted from: Silverman et al, *Skills for Communicating with Patients*; p.93-94]

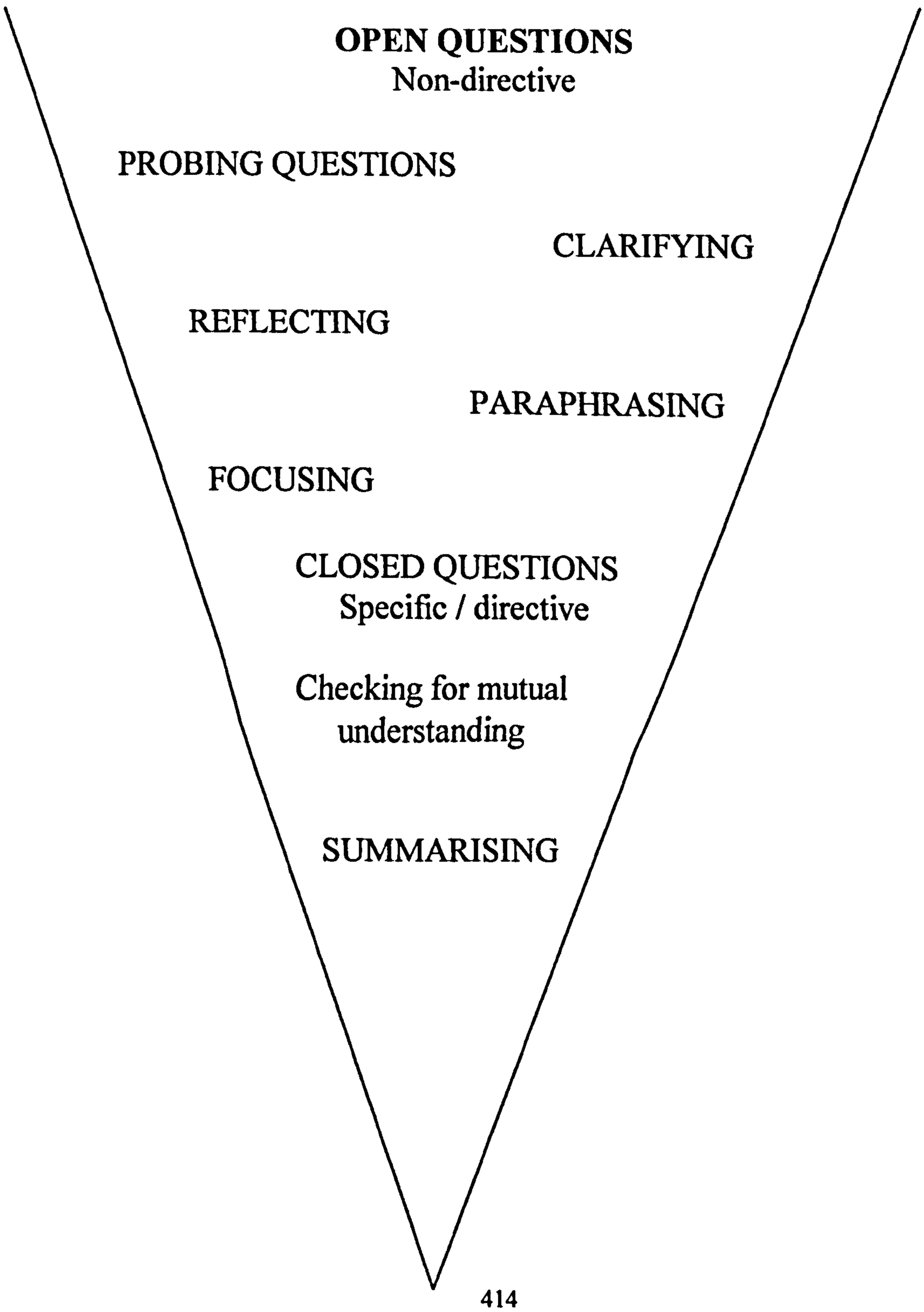
Clinical Context

If you are explaining a procedure or treatment to a patient there are 6 key points you will need to cover:

- Patient preparation or pre treatment care
- The procedure/treatment itself
- Post procedure maintaining treatment
- Risks and benefits
- Alternative choices
- Follow up arrangements/results

EXPLORING SKILLS

This diagram highlights a number of the communication skills involved in exploring patients' ideas, concerns, expectations or problems. The inverted cone shape illustrated below represents the overall movement in the exploring stage of the interview from open-ended questioning, through probing, clarifying and checking, to the point of mutual understanding. However, as the patient interview is always a dynamic process, it may not follow a 'neat' linear progression and there may be some movement back and forwards through the stages of exploration outlined below.



Essential Reading

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CONTENTS

INTRODUCTION

Thank you for agreeing to facilitate a group in this symposium. During this year students will be offered two Communication in Healthcare symposia. The main themes to be covered are:

- Communicating with the young, elderly and relatives
- Dealing with crisis

Both symposia will have the same structure, but the content will be specific to each block.

A menu of additional sessions will be held in the Communication Skills Unit in the Clinical Skills Centre in Shepherd's House on Guy's campus. These will be offered on a sign-up basis to students and some may be shared with nursing students nearing finals and newly qualified nurses. Students will need to check the notice board in reception of the Chantler Clinical Skills Centre for topics to sign-up to.

Symposium design

Number of students: 120. Small group size: 10-15

Each student will have 90 minutes of role play and 90 minutes for video and directed reading.

For the first 90 minutes, 60 students will be divided into 6 groups of 10 for role play. The other 60 students will watch a video and be given directed reading. In the second hour the groups will swap around.

Each group will do 3 role plays, each one lasting 30 minutes. This will be repeated for the second group. The video will be set up in a classroom for students to watch and rooms made available when possible for directed reading. Otherwise students can use the library for this.

CHILD HEALTH, DEVELOPMENT & AGEING

CHDA: ROLE PLAY 1

Explaining a renal ultrasound scan to a child and parent

Learning objectives:

Through role play the students will have the opportunity to practise, and should be able to demonstrate, the following:

- The use of every day language at a level the child will understand and check for understanding.
- Appropriate use of aids to help understanding
- Elicit the child's and parent/s concerns
- Encourage the child to ask questions
- Allow parent/s time to talk about concerns and acknowledge such concerns
- Reach a stage of mutual agreement with child and parent/s as to what will happen next.

Through a role play scenario students will have the opportunity to practise explaining the need, process and likely outcome of a renal scan to a child [age to be confirmed]. Explaining skills include relationship skills of developing rapport and demonstrating empathic responses, matching language, providing complex clinical information in an understandable form and checking for understanding. Students may want to use aids to help.

Medical Student task

To explain the purpose and procedure and likely outcome of a renal scan to a child.

Scenario

Child A has been referred to the paediatric department with a 9 month history of urinary tract infections [bladder or wee infections]. The consultant has examined the child and wants to send her/him for a renal ultrasound test [scan]. The medical student task's is to explain to the child and parent the patient preparation, the test itself and what happens to results.

Child's Medical details

Main problem: You are fit and well apart from the regular wee infections you have been having. Your GP has sent you to the hospital to see a consultant who looks after children [paediatrician]. The Paediatrician wants you to have a special test called a renal ultrasound or scan.

Signs and symptoms: When you have an infection you feel poorly. You get a headache when your temperature goes up and feel hot and sometimes shivery. You need to go to the loo a lot to wee and when you do it is only a small amount. It hurts when you wee. It feels hot and stinging. Sometimes you get a dull pain low in your tummy.

Affect on daily life: You have to stay off school for 2 or 3 days at a time. You sometimes worry about when it is going to happen again. You are getting fed up and want to feel better. Sometimes you feel a bit embarrassed about it.

Behaviour: You can ask the medical student questions about the test. You can tell her/him if there is anything you do not understand and anything that worries or scares you. **Parent behaviour:** You are anxious to understand what happens in the test, will it hurt? How long will it take? When do you get the results?

Feedback to student: The student will need feedback on how well s/he has explained the process and procedure of the scan. Feedback specifically on: language used, pitch, tone and pace of voice; the student's ability to encourage and answer questions and to check for understanding; student's development of rapport with the child.

CHDA: ROLE PLAY 2

Explaining asthma to a child and parent

Learning objectives:

Through role play the students will have the opportunity to practise and should be able to demonstrate the following:

- Explore a common childhood problem with parents and child.
- Elicit concerns and anxieties.
- Use appropriate verbal and non verbal communication skills ie: effective listening, questions styles and empathic responses.
- Demonstrate flexibility of every day use of language to match the child and parents and use or suggest aids to help with explanation and follow up support.
- Check for understanding with both child and parents.
- Mutually agree what will happen next.

Through a role play scenario students will have the opportunity to demonstrate verbal and non verbal skills needed to explore a common childhood health problem, ie: asthma, with an 8-10 year old child and parents. Skills will include relationship skills, effective listening, appropriate questions styles, use of language, exploring the beliefs and concerns of the child and parents and checking for understanding. Ideally the students will bring in positive ideas and examples of managing asthma. The student should end by mutually agreeing what will happen next.

Medical Student task

To explore a common childhood health problem with a child and parent/s.

Scenario

Child, 8-10 years old, has suffered frequent coughs and chest infections over the last couple of years. S/he has been referred from general practice. S/he has had respiratory function tests and is now diagnosed as having asthma. The medical student's task is to explain to the child and parent what asthma is, how it affects children and the type of medication the child will be prescribed.

Child's Medical Details

Main problems: You have no other big health problems. You have had lots of antibiotics for coughs and 'chest infections'. You have been to see your GP lots of times. You have had some tests at the hospital to see how your lungs are working.

Signs and symptoms: When you have a bad chest you find it more difficult to breathe. You get wheezy and it has made you feel a bit scared sometimes. Your chest feels tight and a bit sore. It is sometimes worse at night. The irritating cough sometimes stops you getting to sleep. Then you feel tired and grumpy the next day.

Affect on daily life: You are getting fed up with your chest problems. You have to miss school regularly. You like to play sport [pick something you like and stick to it eg: gym/netball/football]. You have found that you cannot run about as much as you want to.

Behaviour: You have overheard you might have asthma and you can ask the medical student some questions to help you understand more about it. You want to know if you can still play your favourite sport. Can you still have a pet cat, dog, rabbit etc? [Pick an animal you have as a pet at home, or one you would like to have if your Mum and Dad let you.]. **Parent's behaviour:** You are clearly worried, but are trying to hide your anxiety from your child. You need to ask about using the inhaler. [The student ought to give a provisional explanation]. You then ask if anyone can spend some time teaching you and your daughter/son about medication in more detail and where you go from here. S/he may offer suggestions about nurse specialists, voluntary agencies and support groups.

Feedback to student: The student will need feedback on how well s/he has explained asthma and treatment. Feedback specifically on: language used, pitch, tone and pace of voice. Student's ability to encourage and answer questions and to check for understanding. Development of rapport with the child.

CHDA: ROLE PLAY 3

Making Difficult Decisions: End of Life Decisions

Learning objectives:

Through role play the students will have the opportunity to practise and should be able to demonstrate the following:

- Elicit relative's own beliefs and wishes demonstrating appropriate questions styles, good listening skills and empathic responses.
- Explain the implications of different courses of treatment and checking for understanding.
- Allow time for relative(s) to absorb information and use of silence.
- Acknowledge and share patient's known wishes, if any, with relatives.
- Mutually agree the next stage of decision making and treatment.

Through a role play scenario students will have the opportunity to demonstrate the verbal and non verbal skills needed to explain the implications and likely outcomes of treatment and /or relief of symptoms in a seriously ill elderly person. Mutual consent for the next stage of decision making and treatment is one of the main aims of this scenario. Ethical issues such as individual autonomy, prior knowledge of patient's wishes, living wills and medical futility may need to be shared with relatives. Relatives' own beliefs and views will need to be elicited.

Medical Student task

To discuss treatment options and likely outcomes with relatives.

Scenario

Mrs Tanner's mother [Mrs Blanche] is aged 85yrs and is 3 days post severe stroke. She is unconscious, suffering from heart failure and is developing a chest infection. She is currently having IV fluids. She was suffering from increasing morbidity following a previous stroke and late onset diabetes. Even if her chest infection is treated she is still unlikely to recover. She has been in a nursing home for a year prior to this event. Mrs Tanner is Mrs. Blanche's only daughter

[she has a brother abroad] and is very close to her mother. She visits every day. Your task is to explain the treatment options and likely outcomes to Mrs Tanner. Mrs. Tanner is not expected to make a decision in this role play but the student will ask her to think about and discuss her mother's situation with her family and come back to tomorrow.

Profile

Mrs Tanner, 50 – 60yrs.

Work: Part–time secretary in local plumbing firm 08.30 – 15.00 Mon – Fri. You have worked there for many years, more or less runs the whole office. You enjoy your work.

Family: Married with 2 grown up sons who still live at home, 1 at college, eldest works with husband. Husband is a self employed builder. Close family, no real problems. Your father died 10yrs ago. Your mother never really seemed the same after his death.

Home: Owner occupied 3 bed semi in London Suburb

Personal characteristics: Home loving, hard working woman. Conscientious and want 'the best for your mum'.

General daily activities: Home and garden. You go to a dance club with your husband twice a week. Very home and family oriented.

Behavioural characterisitics: Fairly quiet, demonstrate anxiety – clasp hands, sit tensed and upright. You are beginning to fear the worst and that your mum is not going to recover. On the edge of tears.

Additional problems and concerns:

You suspect that you are going to have to make a very difficult decision and talk it over with your family. You wish your husband had come with you. Your youngest son is particularly close to his Grandmother and you think he will take it quite hard.

EMERGENCY MEDICINE, TRAUMA AND LOCOMOTION

EMTL: ROLE PLAY 1

Dealing with Anger and Belligerence

SETTING: Emergency and Accident Dept

Learning objectives:

Through role play students will have the opportunity to practice and should be able to demonstrate the following:

- Ways of ensuring the patient gets assessed appropriately. [knows triage system]
- Demonstrate skills to calm the angry friend.
- Lists steps to take to ensure safety of self, patient and staff.

Medical Student Task

You are a 4th year medical student based in A&E. It is 11pm on Friday night. You have been asked to carry out a preliminary assessment of this patient, Mr Dean Walters, who has been involved in a fight and has injured his head. He is accompanied by his friend who has become noisy and belligerent in the waiting room. Your task is to deal with the friend and to do a basic assessment of the patient's injury.

Scenario

Dean Walters, 23 yrs

Occupation: Plasterer with local building firm

Lives at home with family - mum, dad and 2 younger brothers [15,11 yrs]

No relevant medical history except knee ligament injuries playing football. You were in plaster 18 months ago for 6wks.

Significant relationships: Recently split up with live-in girlfriend [Gemma] which is why you are living back at home. Hope to get back together, she will only have you back if you get engaged. This night out was organised by your best mate 'to cheer me up'.

Daily activities: Outside of work you train for the local football team once a week and play most weekends. Likes clubbing and pubs with mates.

Medical problem

You got involved in a fight at a club. You fell backwards and hit your head. Your friend says you passed out. You have also been drinking all night - around 6 pints of lager and 3/4 Jack Daniels. **Signs and symptoms:** You are a bit drowsy and slurry, but responsive. You feel tired and your head hurts a bit where you banged it [the back of your head].

Behaviour:

Your signs and symptoms are probably more related to your alcohol intake, but the medical student has to examine you to check for head injury. You are feeling very sorry for yourself and say "*I want Gemma - Where's Gem?*". You are generally co-operative. It is your friend who is the problem. You ineffectually say *"Leave it Gary"* when he starts on the medical student.

Dean's friend

Gary Packard, age 22 yrs

Behaviour: You are quite belligerent and verbally aggressive in the casualty department. You have also been drinking, but not as heavily as Dean. You talk loudly and lean forward into the medical student's face,

> *"We have been waiting for over an hour out there in the bloody waiting room. If he's had a brain hemorrhage I'll go to the papers...I tell you I will. FUCKING USELESS hospital. You're not even a proper bleedin' doctor. What is this...don't he deserve a real doctor or what? Nurse!... [you shout off in a direction]. Get someone who knows what the fuck they are doing...."*

You do start to clam down if the student tries to calm you, says that she/he does know what to do or actively involves you in gaining the history of the injury. You will turn around and apologise if the student wins you over.

> *"Sorry darlin'/mate - I'm just worried about him. He's having a rough time at the moment you know. We always look out for each other*...[etc]....".

If the student ignores you or makes no attempt to acknowledge your concerns for your friend, you will remain belligerent and obstructive - but not physically aggressive!

EMTL: ROLE PLAY 2

Dealing with Emotion: Breaking bad news

SETTING: Emergency and Accident Department

Learning objectives

Through role play the students will have the opportunity to practise and demonstrate the following:

- Rapport and empathy skills
- Explain what is happening sensitively
- Pace information given
- Clarify and check for understanding
- Demonstrate emotional support for the patient

Medical Student Task

Mrs Neeran who is 12 weeks pregnant, has been admitted to A&E with abdominal pains and bleeding. A scan has confirmed she is miscarrying the baby. You have accompanied the O&G Registrar who has broken the news of the inevitably miscarriage to the patient. The Registrar is bleeped and leaves the cubicle saying s/he will be back shortly. The student remains with the patient. The student's task is to respond to the patient's emotional state and to any questions she may ask.

Scenario

Mrs Neeran, 24 - 30 yrs

Occupation: Solicitor

Lives with: Married for 2 yrs to a company accountant

Family and significant others: 2nd generation. Close family. Both parents alive, Father retired lecturer in cultural studies. Mother never worked outside the home, 3 brothers as well. No major family problems.

Medical problem

This is a planned pregnancy, much wanted baby. It took you 9 moths to get pregnant, (which felt a long time to you). You and your husband had been talking about the 'right time' to have a baby for some time beforehand. You are 12 weeks pregnant and have recently announced your pregnancy to close family and friends plus colleagues at work.

You have been 'spotting blood' for a couple of days and had made an appointment to see your GP. [Ironically your appointment is this evening]. Your friend has brought you in to Casualty as she thought you needed to be seen urgently.

Signs and symptoms: You have had vague abdominal discomfort for the last 5 days. This discomfort has turned to lower abdominal pain with frequent painful spasms. You started to bleed heavily this morning and have past several large clots during the day.

Additional problems

Your husband is away on business in Brussels until tomorrow. You did not tell him you had vague discomfort before he went [3 days ago] and did not want to worry him on the phone. You now realise you are going to have to tell him what is happening and he will want to cut his business trip short and return if he can get a flight tonight.

Behaviour

You are quite frightened and a little tearful. The pain is strong and the large clots and blood passed have alarmed you. You keep wrapping your arms around your tummy and rubbing your lower abdomen. The realisation that you are losing your baby has hit you and you desperately want your husband to be with you. You also apologise several times for getting upset. Towards the end of the role play you tell the student that your friend has gone to make some phone calls to your family. You ask if she can come in with you when she returns.

EMTL: ROLE PLAY 3

Communicating with a Relative

SETTING: Emergency and Accident Department

Learning objectives

Through role play students will have the opportunity to practise and should be able to demonstrate the following:

- Rapport and empathy skills
- Pacing of information given and appropriate use of silence
- Clarifying and checking for understanding
- Demonstrate support for emotional state of father.

Scenario

Miss Sara Calman, age 18 yrs, has been knocked down in a road traffic accident. She was on a zebra crossing and a car failed to stop. She has a head injury, fractured pelvis and severe injuries to her right leg. She has lost a lot of blood and was brought into A&E unconscious and very shocked. She had a CT scan which showed a sub-dural haemmorage. There are no other obvious injuries. She has been taken to theatre for emergency surgery. Surgery to:- Drain haematoma and repair open fractures to tib and fib as well as severed soft tissue damage. Surgeons are confident that surgery will be successful but recovery and rehabilitation from leg injuries will be a long term task.

Medical student task

Mr Calman is Sara's father. The police have contacted him at work and informed him that his daughter has been injured in an accident and taken to Casualty. Mr Calman has been asked to sit in a relative's room [or office] where you will be expected to let him know how his daughter is, the seriousness of her condition and possible outcomes. She is seriously ill but surgery is going well and is likely to be in surgery for 2-3 hrs. She will need intensive care support post operatively.

Relative Profile

Mr John Calman age 50 - 55 yrs

Occupation: Technical editor in publishing company

Family set up: Lives at home with wife and 2 daughters. Sara [patient] and Claire age 15 yrs. Wife works part time in an insurance office.

Housing: Owner occupier - terraced town house

Medical problems: Not relevant for this scenario

Additional problems: Telling your wife and other daughter. Your wife tends to be quite 'highly strung and a real worrier'. Claire and Sara argue like mad but are very close and protective of one another.

Behaviour: You try to keep a stiff upper lip and ask sensible questions such as;

"How much damage is there to her leg? ... Are there any internal injuries? ...Was she conscious? ...Does she know what has happened to her?"

You are very close to your daughter and can't bear to think of her feeling frightened or in pain. You want to stay at the hospital but know you will need to collect your wife. You begin to let your fear and anxiety show,

"She will be alright - won't she?"

You are now close to tears and desperate to see your daughter. You definitely want to be with her when she comes out of surgery. You suddenly begin to get agitated and quite angry about the driver of the car.

"Where's the driver - who is it - what were they thinking of? What will the police do.... I will prosecute etc.".

If the student manages to calm you then respond by quietening down and by putting your head in your hands or similar gesture. You decide to wait a bit before going to collect your wife.

CONTENTS

INTRODUCTION

INTRODUCTION TO MBBS YEAR 5

Thank you for supporting the integrated Communication in Healthcare Curriculum by facilitating a communication skills group. As a vertical strand throughout undergraduate and postgraduate medical education the only way the courses can run is by health professionals and allied tutors 'signing up' for tutor training sessions and facilitating groups. If each clinical team put forward one facilitator every six months then we would soon have a flexible active database of clinical communication tutors. Please, please can I urge you to do so. Junior doctors, SpRs and experienced nurses are as welcome as consultants. (Also useful to add to CVs).

There will be three Communication in Healthcare sessions throughout Year 5, one in each campus block. Each campus block will comprise of two 90 minute sessions of three role play scenarios using professional role players and trained volunteers. Each student will have 90 minutes of role play and 90 minutes of directed reading.

14.00-15.30: Sixty students divided into 6 groups of 10 for role play.
60 Students have directed reading.
15.30-17.00: All groups swap around for the second hour.

In addition a plenary sign up session will be arranged for students to attend during the campus block with presentations by guest speakers/clinical specialists on relevant subject areas.

Thank you again.

ELAINE GILL
Head of Communication Skills Unit

COURSE OUTLINE

CAMPUS BLOCK 1: CROSS CULTURAL COMMUNICATION AND COMPLAINTS

Plenary presentations:

- Cross cultural communication and complaints - Service user's perspective
- Patient and relative complaints -Acute sector
- Working with interpreters - National and local resources
- Informed consent - Culture and influence

Role plays:

- English as a second language
- A relative's complaint
- Sudden death - biomedical and religious difference

Learning objectives:

On completion of this session learners will be able to:

- List key points of good practice when dealing with a patient or relative's complaint.
- Demonstrate effective skills when communicating with someone with a limited understanding of English.
- Demonstrate effective understanding in the light of religious or cultural differences.
- List criteria for informed consent.

CAMPUS BLOCK 2: BREAKING BAD NEWS & DEALING WITH DEATH AND DYING

Plenary presentations:

- The role of voluntary agencies for cancer patients and their families
- Practical advice for the bereaved
- Patient's perspective

Role plays:

- Dealing with an angry relative
- Breaking bad news to a patient
- Breaking bad news to a relative

Learning objectives:

On completion of the session the learners will be able to:

- Demonstrate effective communication skills when breaking bad news.
- Demonstrate effective communication skills when dealing with anger and hostility.
- List main principles and procedures to be followed when a patient dies

CAMPUS BLOCK 3: INTERPROFESSIONAL COMMUNICATION

Plenary presentations:

- Communication in teams and clinical mistakes
- Nurses perspective of working with PRHO's

Role plays:

- Discussing patient care with another health professional.
- Dealing with interprofessional conflict.
- Concerns about a colleague.

Learning objectives:

On completion of this session learners will be able to:

- List the principles of effective communication in healthcare teams.
- Demonstrate ways of managing interpersonal conflict with another health professional.
- Propose a strategy to address concerns about a work colleague.

CLINICAL COMMUNICATION OBJECTIVES

The following clinical communication objectives build on the previous year's learning objectives. The final year student is expected to demonstrate and integrate the longitudinal vertical strand of communication in healthcare learning as part and parcel of being an effective clinician. Therefore, the following Year 5 skills are not to be viewed as the only skills needed in Year 5, but that these skills will be specifically assessed.

EXPLAINING SKILLS

On completion of Year 5 the student should be able to:

Explain a procedure, common surgical and medical treatments including the following criteria:

- Preparation and pre-intervention care
- The intervention
- Risk factors
- Post intervention care, likely outcome and follow up

The student should:

- Use language the individual understands and avoid unexplained medical jargon
- Elicit the individual's concerns and encourage questions
- Demonstrate verbal and non verbal empathic responses
- Check for understanding from the individual's and doctor's perspectives
- Summarise the main points and individual's concerns
- Reach mutual agreement about the course of action
- Conclude the interview effectively

NEGOTIATING SKILLS

On completion of Year 5 the student should be able to:

- Elicit an individual's expectations
- Explore the individual's main concerns
- Acknowledge the individual's ideas, beliefs
- Demonstrate verbal and non verbal empathic responses
- Explain the medical view clearly using language the individual understands
- Encourage questions
- Discuss options and possible outcomes with the individual
- Check for understanding from individual and doctor perspectives
- Avoid defensive or intransigent behaviours
- Reach mutual agreement about the course of action
- Summarise and conclude the interview effectively

BREAKING BAD NEWS

On completion of Year 5 the student should be able to:

- Prepare the patient/relative for breaking of bad news and check patient/relative's circumstances
- Elicit understanding so far
- Indicate the serious nature of what the student-practitioner is about to say
- Give information in small chunks and pace carefully
- Appropriate use of silence
- Demonstrate verbal and non verbal empathic responses
- Check for mutual understanding
- Agree what happens next
- Summarise and conclude the interview effectively

CROSS CULTURAL COMMUNICATION
ROLE PLAY 1

ROLE PLAY 1: English as a second language

Student task

The patient you are about to see does not speak fluent English. Your task is to establish the patient's main complaint and to offer advice which is understood.

Patient Profile

Mr/Mrs [...]; 20-30 years; Chinese/Portugese/Vietnamese/Russian [anything except French or Spanish!]

Work status/type: Student; travelling around Britain for 1 month vacation with 3 friends; staying in Youth Hostel with 3 friends who have come on vacation with you.

Family set up: Both parents are teachers, younger brothers and sisters back in native country [probably not relevant for this scenario].

Medical History: You are a fit and healthy individual with no particular health problems or allergies that you know of.

Personal characteristics: You have a smattering of English [enough to get you by in shops and restaurants]. You are not good on long sentences. You know the word antibiotic and try to get across to the student that you want a prescription. You look a little anxious. This is due mainly to not wanting to disappoint your friends for missing out on things because you are ill. You seem puzzled if the student does not offer to write you out a prescription straight away. You get confused between the terms 'hot' and 'cold' [ie temperature], and 'neck' and 'throat'. You need to allow the student time to try different techniques and strategies to increase understanding. Therefore do not agree too easily with everything. However don't be completely obstructive. We want the student to have some success.

Current health/medical problems:

You have been feeling generally unwell with a headache for 24 hours and now you have a sore throat and cold symptoms. You have not taken your temperature or any tablets. You have come to see the GP as a temporary resident and expect to be given antibiotics. You have tried to buy them over the counter from the chemist prior to seeing the doctor.

Role Player note:

The student may not be keen to give you antibiotics and suggests you drink plenty of fluids and take paracetemol. At first you are not keen, but if the student demonstrates effective skills and behaves respectfully and empathically then you agree to this.

CROSS CULTURAL COMMUNICATION
ROLE PLAY 2

ROLE PLAY 2: Sudden death; Biomedical and religious difference

Student task:

Mr Steinman's son Josh, age 20, was admitted to A&E following collapse on the football field this morning. Despite the paramedics and A&E team's best effort, Josh was unable to be resuscitated. Mr Steinman has been informed of the death and has spent some time with Josh before he is taken to the mortuary.

Your task is to discuss with Mr Steinman that a post mortem will need to be carried out to ascertain the cause of death. His wife is still at Josh's bedside and is too distressed to come away.

Relative's profile:

Mr Steinman, 40-60 years;

Work status/type: Accountant

Family set up: Married to Sarah. Large close extended Jewish family. 3 sons, Michael, Simon [older] and Josh [20yrs]. 1 daughter [17 yrs]. Three brothers, father died 3 years ago. Mother now lives with your family. Numerous cousins and friends in the Jewish Community.

Scenario:

You received a call from casualty department and you and your wife came straight away. Hannah informed her brothers that Josh is in hospital and they are on their way together shortly. They do not know that Josh has died.

It is custom for you to arrange the funeral and burial service within 24 hours. However the young doctor needs to discuss with you the prospect of a post mortem due to the sudden

nature and unexplained cause of death. Ultimately it is the coroners' decision whether to go ahead with post mortem or release the body for burial.

You are clearly devastated and shocked. The need to adhere to your religious beliefs is strong. Rationally you understand the need to find out the cause of death but emotionally you need to carry out religious rituals and processes without interference from others. *"I can't believe this, I just can't believe it. My beautiful strong son"*. The doctor's suggestion that the case will have to go to the coroner and a post mortem may be required means that you will not be able to bury Josh within the customary time. Your immediate reaction is to *say "No, give me my son, I need to take him home"*.

Role player note:

The doctor needs to handle this distressing time sensitively and respect your wish to avoid post mortem if possible. This is a difficult situation as in time you may feel a real need to know the cause of death and you are having difficulty dealing with the conflict of religious need, emotional response and rational decision making.

CROSS CULTURAL COMMUNICATION
ROLE PLAY 3

ROLE PLAY 3: Dealing with a Complaint

Student task:

Ms Mendez's mother has recently been admitted with acute chest pain and shortness of breath and has had a severe myocardial infarction since admission. Ms Mendez has asked to see a doctor. She is not all happy with her mother's treatment so far. Your task is to listen to her concerns and questions and deal with her potential complaint.

Relative profile

Ms Mendez; age 35-55; white/asian/black

Work status/type: Primary school teacher, teaching 10-11 year olds

Lives in a large Victorian two bedroom converted flat, with a garden in Lewisham.

Family set up: Living happily with your partner, Freddie, who works for the RSPCA; no children; several pets [2 cats; dog; rabbit].

Personal background: Father died when you were a child, so raised primarily by your mother who is now 78. You live quite near her (20 minute drive) and see her almost every weekend. You have frequent telephone contact with her as you worry about her being on her own. She is still very independent and manages to get out, but has a home-help twice a week to do shopping and cleaning. You are very close to her and appreciate how well she managed to raise you and your brother as a single parent. Your brother now lives in America. You speak to him on the telephone every few weeks but don't see him very often at all.

Personal Characteristics: Generally a relaxed, calm person, but you are able to be assertive and put your foot down, (as your are frequently required to do at school!). You are intolerant of anything that you perceive to be unjust, and this brings out the strident side of your nature. You can be persistent and outspoken. You are not easily put off of your track if you think you are in the right.

Current Situation

Your mother, Elena Mendez, was admitted to the A&E department of her local hospital with chest pain at 11:00am on Saturday morning. She phoned you to say that she had called an ambulance and you rushed to the hospital, arriving shortly after her. You stayed with her while a junior looking doctor came to examine your mother. After asking some questions and examining her, he went out of the cubicle without saying very much to you. Shortly afterwards, a nurse came and took your mother's blood pressure and pulse, did an ECG (heart trace) attached her to a cardiac monitor. She gave her a couple of tablets to put under her tongue for the pain and left.

The doctor came back and took some blood. He told you your mother seems to have angina and that his registrar would be along shortly to examine her again. You then waited approximately two hours for the Registrar. He ordered aspirin and GTN tablets to be given to your mother, and told you your mother probably had not had a heart attack, but would be admitted overnight for observation. You then stayed with your mother for eight more hours until a bed was found. By then your mother was very agitated, tired and distressed by the sights and noises in the A&E department. She also could not lie down comfortably, as her back and bottom were so sore from lying on the trolley. You got her settled into the ward and went home exhausted.

At 4 o'clock the next morning, you received a phone call from the hospital. The nurse told you that your mother had taken a serious turn for the worse having had a serious heart attack and was now in the cardiac intensive care unit. You immediately go to the hospital to see your mother, who is not responding to you. You are deeply upset by what has happened and are absolutely certain that this is a direct result of her treatment in the A&E department.

You demand to see the doctor in order to make an official complaint. You are barely able to control your anger and upset, but do not break down. You catalogue your long wait, your mother's discomfort, lack of communication or any sense of compassion from the staff in A&E. You will say that you view your mother's condition as a direct result of negligence and lack of proper care on the part of the medical and nursing staff. You say you are making an

official complaint and will take it to the highest level, even the press if necessary. You ask for the doctor's name and say you will name him/her as one of those involved.

Behavioural Characteristics:

You are a talkative person, used to talking to the children at school. You are generally self-confident. However, you are very upset at present by what has happened to your mother (you have a tissue in your hand) and you can easily become tearful at the thought that you might lose her. You are extremely angry at what has happened to her in hospital, but do not want to lose control of yourself. This is palpable through your accusatory tone of voice, facial expressions and tense body posture.

Role Player note:

The medical student's task is to deal with your concerns and complaints in a constructive way. If s/he displays a lack of empathy or defensiveness, you will continue to vent your frustration and persist with your intention to make the complaint. You will ask the student to tell you how a woman with your mother's condition should have been treated. If the student responds empathically, perhaps saying that they are sorry that things went the way they did, is not defensive or 'passing the buck', your manner will soften towards them. You may still make your complaint, but might aim this at the lack of resources rather than at individual clinicians.

ROLE PLAY 1: Breaking Bad News

Student task

You are an SHO in a Rheumatology Clinic. Mr Phillips, a Judo Instructor, has come to the clinic to get the results of blood tests to investigate the pain and stiffness he has in his knees and hands. The results and his symptoms are consistent with a diagnosis of rheumatoid arthritis. You have to break this news to him.

Patient Profile

Kevin Phillips, male, 35-45

Work status/type: Self-employed, runs a Judo School and provides personal training in keep fit and marshal arts.

Family set up: Lives with his partner, Susan, and son, Paul, who is three years old. They live in a semi-detached house in South London (big mortgage). Susan works part-time as a classroom assistant. Mother fit and well, father suffers with mild arthritis but still active.

Personal characteristics: You are a very motivated, active man. You are very fit and have excelled in Judo and Marshal Arts through hours of practice and persistence. You are proud of the business you have built up over the years and keenly follow the progress of your students through competitions. You are driven to succeed and are determined to provide a high standard of living for your family through your hard work.

Behavioural characteristics: You are very 'clean living', don't smoke and only occasional alcohol. You have no underlying health problems. Your parents are alive and well. Your days are busy with classes and seeing clients for one-to-one training. You spend what time you can with Susan and Paul. You are used to directing others and being in control, not generally expressive about your feelings. You do care deeply for your family and your work, and are deeply upset when you learn that these are threatened.

Current health/medical problems:

You have been experiencing some discomfort and stiffness in the joints of your knees and hands and feeling very tired over a period of months. At first you thought it might be due to strain from intensive work but it has not subsided despite your efforts to cut down on your physical training. You still think that it is something that will get better and desperately want some treatment so you can resume your normal schedule.

Behavioural Characteristics

When the doctor breaks it to you that you have rheumatoid arthritis you are extremely shocked. You repeat from time to time that you can't believe it. You know that you are a fit person and can't understand how this can happen to you. You know that it is a chronic condition and cannot bring yourself to think of what will happen to your business and how you will support the family. You can't bear the thought of being in a wheelchair as your son grows up. You try hard not to lose control of your emotions, but are on the brink of tears.

Role player note:

When giving feedback to the student please ensure that you concentrate on the specific breaking bad news skills, including pacing of information, silence, emotional support and empathic responses.

BREAKING BAD NEWS
ROLE PLAY 2

ROLE PLAY 2: Dealing with an angry relative

Student task:

You are a PRHO at a surgical firm. It is 7pm and Mrs Morgan has demanded to see the doctor who is looking after her mother, Mrs Doyle. Mrs Doyle (age 70) is 4 days post hysterectomy. Her recovery has been complicated by unstable diabetes. Earlier this afternoon she developed a pulmonary embolism and is on a heperin drip and oxygen therapy. She appears to be responding to treatment. You are not sure what Mrs Morgan wants, but the nurse says she 'seems a bit put out'. Your task is to respond to her concerns.

Relative's profile:

Elizabeth Morgan, female, 40-50

Work status/type: a qualified nurse. Works part-time in a medical out-patient's clinic.

Family set up: lives with her husband, Ian, and daughter, Lisa, aged 18. Her son, Paul, is at University and comes home most weekends. Husband works for an insurance company. Daughter is doing A levels. Home life is generally happy. Elizabeth's mother (Mrs Doyle) is widowed and lives nearby. The whole family is very close to her and see her regularly. Mrs Doyle is diabetic (insulin-controlled) and has had some gynaecological problems over the past year.

Personal characteristics: You are an assertive and forthright person. You have clear ideas on how things should be done and are not very open to alternative suggestions. You are also kind and caring by nature and will put yourself out to help others. You are very protective of your family.

Current medical problem:

Your mother had a hysterectomy four days ago. She seemed to be recovering quite well despite her diabetes being difficult to control. However, when you go to visit her this evening, you find her in pain, short of breath and very worried (she is having a special drip 'heparin' to

thin her blood and has an oxygen mask on). The nurse tells you that she developed a 'clot on the lung' earlier in the afternoon, but that she seems to have stabilised now.

From your professional knowledge you know this is a serious complication (a pulmonary embolus) and are very angry as you think this could have been avoided. Your mother complained of pain in one of her calves the previous day, which you reported to a junior doctor on the ward and a nurse. You told them you were worried in case she was developing a blood clot. They assured you it would be looking into. As far as you know, nothing was done about it (either medically or nursing) and now your mother is very ill.

Behavioural Characteristics

You are very worried about your mother (you fear this could kill her), and react angrily to the doctor. You find it easier to react this way than to admit your fears. You talk in a raised tone of voice. You say your mother has been neglected and that you warned his colleagues that this might happen. You demand to know why no action was taken and why his team *"doesn't communicate with each other"*. You threaten *"if anything happens to my mother you won't hear the end of it"*. If the student listens to and validates your feelings, you will become calmer, tearful and express your worries. If the student is not sympathetic, is defensive or dismissive, you will become angrier and more hostile.

Role Player note:

When giving feedback to the student please ensure that you concentrate on the specific dealing with anger skills, including listening, validating feelings, non-defensive verbal and non-verbal responses.

ROLE PLAY 3: Breaking Bad News: Death & Dying

Student task:

You are a PRHO in cardio-thoracic team. Mrs Dean, aged 69, has unexpectedly arrested 48 hours post coronary bypass surgery. Attempts to resuscitate her have failed. She is on the ward with the curtains around her. The ward nurse has telephoned her son to tell him that his mother's condition had suddenly deteriorated and that he might want to come to the hospital straight away. He has now arrived and your task it to break the news of his mother's death to him.

Relative profile

Mr Dean, age 25-50 years, painter and decorator

Family set up: Working class family, eldest son, twin sisters 4 years younger. Father died 2 years ago of lung cancer. Very close to mother. Younger sisters both have [small babies if under 35 / jobs further away if older] so you have been elected as the person to notify if needed. Married with a boy and a girl [up to senior school age as appropriate].

Personal characteristics: You are a caring family man who tends to feel responsible for your family's happiness [even when it isn't your responsibility]. You have always felt very protective towards your mother and sisters, even more so since your father died. You are fiercely protective towards your children. The thought of them being upset or hurt through anything is hard for you.

Current Situation

The ward nurse has telephone you to say that your Mother, who is in hospital for coronary bypass surgery, has suddenly deteriorated and suggests that you might need to come up to the hospital straight away. You have arrived on the ward and been shown into the ward office by one of the nurses. You have decided not to contact your wife or sisters until you have some idea what is going on.

Having been shown into the office you have become very anxious and have a sense of foreboding. You demonstrate your anxiety by sitting tensely on the edge of the chair and frowning. When the student breaks the bad news to you, you are stunned into silence and then eventually ask, *"What happened?", "Why?"*

If the student explains gently what happened then you go on to ask *"Was she in pain...did she know"?* At some point say very quietly in a broken voice, *"She was so looking forward to feeling better....just getting on her feet after Dad...".* Wait in silence and then say *"Can I go and see her?"* if the student has not offered to take you to her. *"Oh my wife...the family...I need to do something, get them or something...".* You are clearly shocked and distressed

Role Player note

When giving feedback to the student please ensure you concentrate on the specific breaking bad news skills. Pacing of information, silence, emotional support and empathic responses.

INTER/INTRA-PROFESSIONAL COMMUNICATION
ROLE PLAY 1

Inter and Intra-Disciplinary Communication: Dealing with Conflict.

Patient profile:

Edward Meacher, 78 year old. (This patient is discussed but not seen in this scenario)

Work status/type: Retired greengrocer - had own stall in Borough Market. Gave up work six years ago due to problems with arthritis. Being out in the cold made it worse. Sold his pitch.

Accommodation: Lives in a private flat in a small block, with a lift. It is comfortably furnished and centrally heated.

Social set-up: Widowed 4 years ago, was married to Rose for 49 years. They didn't have any children. Rose used to help on the stall. He has a good neighbour who pops in every day with the newspaper and checks if he needs anything. Has a married brother and nephews who call occasionally and he spends Christmas with them since being on his own.

Personal characteristics: He was always a very popular man with the market traders, friends and neighbours. He is a very courteous and kind man with a good sense of humour. When working he was an out-going person, but since giving up work and losing Rose his world has become much smaller. He is finding it harder to cope with his diminishing mobility, and day to day tasks are becoming harder to deal with. He often feels lonely and does not look forward with any sense of optimism.

Medical history:

He has long standing insulin-dependent diabetes. His eyesight is poor as a complication of this, and he has some paraesthesia in his feet. He developed arthritis in his late sixties which has now worsened, particularly affecting his hips, knees and hands. He has a lot of discomfort from this and his mobility has deteriorated. He rarely goes outside alone now. He was previously a heavy smoker and is prone to bronchitis and chest infections.

Health/social services:

Daily morning visit by D/N to administer insulin + urine/blood glucose test. Twice weekly HCA for bath. Daily MOW's for lunch, 3 times a week home help for cleaning and shopping.

Current Medical Problem:

Mr. Meacher was admitted to the ward a week ago with a severe chest infection. He had not been eating or drinking well and was dehydrated on admission. He has become increasingly more frail in recent weeks. On the ward he was re-hydrated with IV fluids and his chest infection treated with IV antibiotics. He is now eating and drinking normally and his chest infection has cleared up.

He has received physiotherapy to get him mobile again and has been assessed as safe to walk with the aid of a stick. He has had input from the OT to assess his 'Activities of Daily Living'. This has shown he is able to wash himself, but needs assistance with bathing, he can use the toilet independently (provided with handrails and raised seat), and can make himself a hot drink and snacks safely. With re-commencement of his services, Mr. Meacher is now deemed medically fit to return home.

Student task:

You are the PRHO on a busy medical ward. On the ward round it is agreed that Mr. Meacher can go home as soon as services are arranged. The Registrar tells you to get the discharge sorted out and free up the bed asap. You have some concerns as to how Mr. Meacher will manage at home having seen quite a bit of him on the ward. He seems very frail and looked anxious and sad when you told him about his imminent discharge. You think there should be more discussion with consideration of residential care for Mr. Meacher, but put these thoughts aside in the light of both the Consultant and Registrar saying he must go home.

Your task is to meet with the ward sister to ask her to make the arrangements for Mr. Meacher's prompt discharge. You feel under great pressure from your seniors to make sure this happens.

Nurse's profile for the role play:

Name/gender/age: Susan/Sam Collins, mid twenties to thirties.

Professional status: You are the ward sister/charge nurse on a busy medical ward. You have always worked in nursing and are very experienced. You have been on this ward for six years.

Personal characteristics: You are an approachable and reasonable person but you can also be very assertive (as you often need to be in your job). You feel very strongly about the rights of your patients, particularly the frail and elderly as you think they do not always get the care and respect they deserve.

Behavioural characteristics: You are pleasant but direct in your dealings with colleagues. You will put your point across assertively rather than aggressively, but you will stick to your viewpoint if you think you are right.

Current situation:

Dr. X., the PRHO on the ward asks you to sort out arrangements for your patient, Mr. Meacher's discharge. You were unable to go on the ward round because of a crisis on the ward earlier and are shocked to hear that this has been decided. You do not think that Mr. Meacher is fit enough to go home. You think he is far too frail and if discharged is likely:

- to fall - leading to re-hospitalisation.
- To neglect himself, not eating - leading to unstable diabetes.

You think that any amount of services cannot prevent these risks, and that they are not worth taking. You are particularly fond of this patient 'a real gentleman', who is still mentally very sharp. You have sensed from him that he is reluctant to go home, and that he has lost his confidence and the will to remain independent. You will argue that nothing should be done until a proper case conference has been convened with social services present and until Mr. Meacher has been given the opportunity to consider his options (this will take at least a week to organise). You may say:

" He has the right to discuss fully - it's his future"

"You've seen him - does he look up to it to you?"

"I've seen so many like this, he'll fall over, break something, get pneumonia and that'll be the end of him. We've got a duty to see it doesn't happen, unless that's what he wants to risk himself"

"How will we feel if he ends up back in here in a worse state?"

"If you insist on his discharge, I'll document my concerns. I don't agree with at all".

[After this scenario we'll go on to say...

Mr. Meacher was quickly discharged home according to the medical team's plan. He had been at home for a week when he fell over after taking his 'meals on wheels' from the lady who delivered it. He had not had a proper breakfast, only a cup of tea and had been given his insulin by the D/N. Mr. Meacher was unable to get up off the floor and developed a hypoglycaemic coma. His neighbour called the police and an ambulance when he got no reply from Mr. Meacher's that evening. He was re-admitted to the ward, unconscious, dehydrated, hypoglycaemic and with breathing difficulties].

INTER/INTRA-PROFESSIONAL COMMUNICATION
ROLE PLAY 2

Student task:

The PRHO involved in his discharge (your colleague) is very distressed when he/she sees Mr Meacher's condition and confides in you about this. S/he feels very guilty for being instrumental in his discharge and for not speaking up about his/her concerns and listening to the nurse. You are working on the same firm and grow increasingly concerned about your colleague. You can see s/he is finding it difficult to cope with the workload and demands. The PRHO in question has been making a number of minor mistakes and omissions which you have covered for, but you are shocked to find a drug chart on which s/he has prescribed a huge overdose of a drug. You know that other colleagues will also see this.

What do you do next? Your task is to discuss your concerns about your colleague with the Registrar and come to an agreement about what to do. In the event you decide to approach the registrar on the firm.

Registrar scenario

Dan /Diana Packard

Married [partner also SPR on different rotation] baby age 6 months. [If female, she has recently returned from maternity leave.] Baby with child minder during day.

Personal characteristics: Very efficient and well organised. Very committed to medicine and patient care, kind but firm. You are normally quite a patient person and try to support junior doctors and nursing staff. You do not like to let people know that you find it difficult to cope at times.

Behavioural characteristics: You are tired and stressed yourself. The baby is teething and you and your husband/wife are having very disturbed nights. You are finding it quite difficult at times to balance family life and new baby with a busy medical rotation. When the PRHO approaches you are terse and short tempered, which is not usual for you. You have been behaving more like this recently.

"Look have you talked to him/her? I really have got enough on my plate at the moment... I just haven't got the time to sit down with him/her this week".

You have had some idea that the PRHO in question has not been coping well but have tried to block it out. You now feel a bit guilty that you have let things ride and show this by your defensive prickly response.

"Have you got any specific evidence to back this up?"

The PRHO will probably tell you about the drug incident.

"Oh – What have you done about it apart from telling me?"

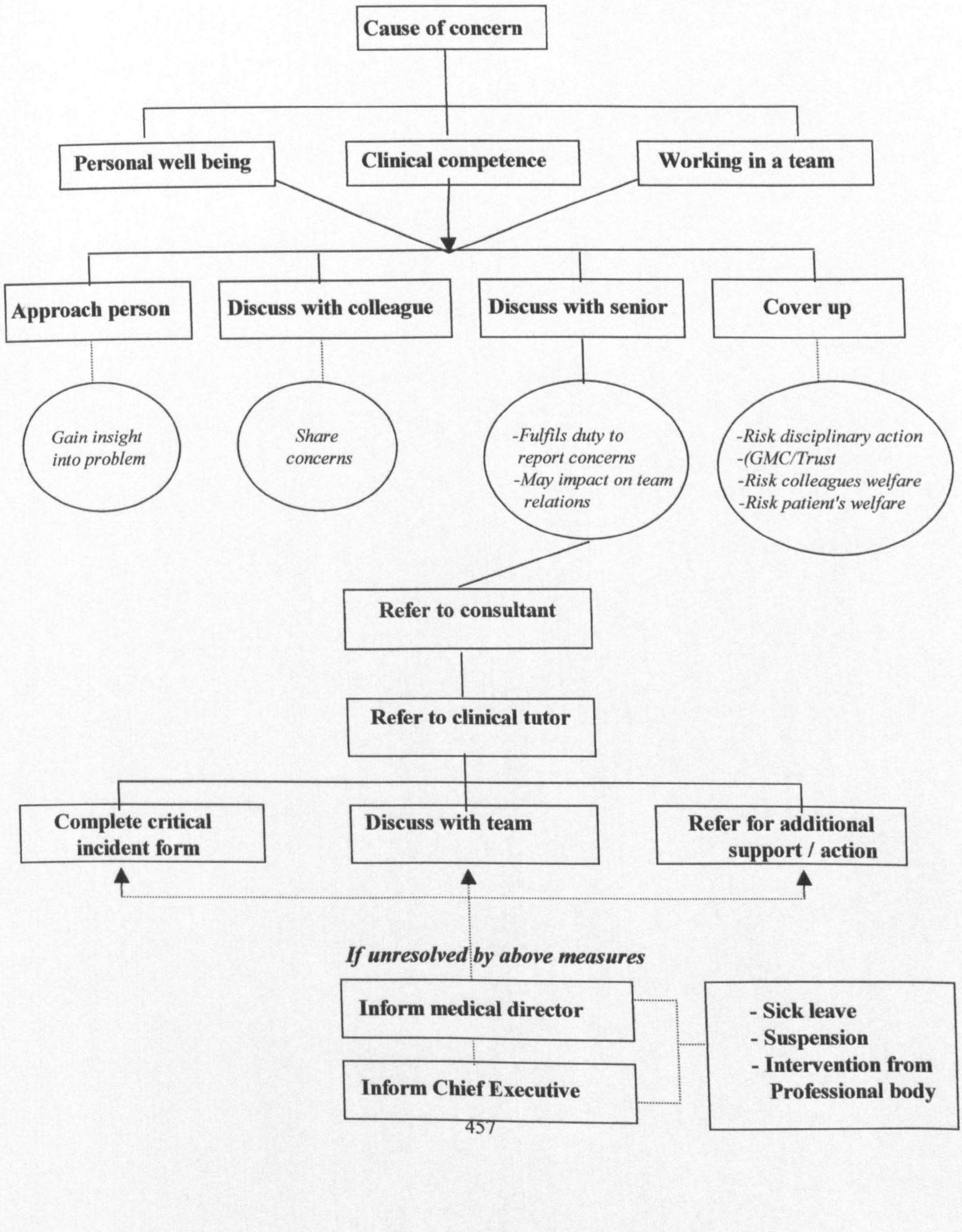
The PRHO has done nothing else at this point.

"Look can't you try and sort this out. Go back and talk to him/her. You PRHOs should be supporting each other you know."

You know in the back of your mind you should be more helpful but you just want to dismiss the PRHO at this point.

INTRA-PROFESSIONAL CONCERNS WITH COLLEAGUES

COMMUNICATION PROCESSES FOR PRHO'S



ERROR MAKING, BLAME AND PSYCHOLOGICAL DISTRESS IN JUNIOR DOCTORS

Studies so far have suggested:

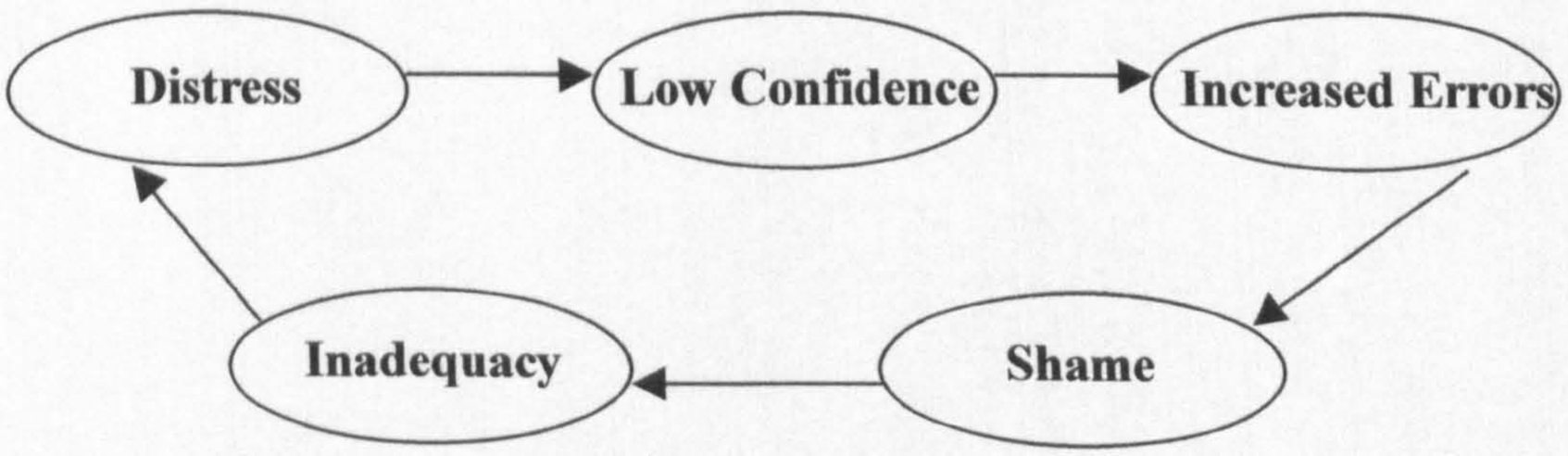
- Perceived lack of support = psychological distress (Garrud et al 1990)
- Perceived lack of training = psychological distress (Dale 1999)
- Higher psychological distress = lower confidence in abilities (Williams et al 1997)
- Higher distress = higher error making (Houlston et al 1997)

Concept of infallibility amongst medical profession:

- Difficulty acknowledging distress (Frith-Cozens 1989)
- Difficulty acknowledging or discussing mistakes (Sexton et al 2000)
- Anecdotal evidence of feelings of shame or inadequacy (Casarett and Helms 1999) and 'culpability' (Mizrahi 1984) if make medical error.

So hypothesis is of a vicious cycle occurring:

- Distress links to low confidence which links to increased errors, but concept of infallibility means error-making produces shame, inadequacy and distress.



This is the area that is, therefore, important to address - the 'perception of error-making' amongst doctors. If we can focus on identifying how making mistakes makes the doctor feel, then we might begin to dismantle responses that contribute to the doctor becoming more distressed and less confident - thus breaking this cycle.

In addition, it may be interesting to look at whether personality factors can mediate/buffer the responses to error-making.

PATIENT-CENTRED INTERVIEW SKILLS GUIDE

OPENING: ESTABLISHING RAPPORT

- **Greeting and introductions**

Verbal and non-verbal message: facial expressions, tone of voice, shake hands if appropriate.

- **Attention to comfort and privacy**

Environment, seating and positioning. Allows patient time to sit down or change position if necessary. Consider individual's accompanying or visiting patients.

- **Awareness of cues that might indicate emotional state of patient**

Verbal cues: tone, pitch and pace of speech. Non-verbal cues: facial expression, body position and tone, hand movements.

- **Checks with the patient for their understanding and purpose of the interview**

Invites the patient to speak. Starts with open questions.

EXPLORATION: MANAGING TIME AND CONTENT CONVEYING EMPATHY VERBALLY AND NON VERBALLY

- **Surveys problems and concerns**

Asks, *'Is there anything else'* e.g.: *'what other problems would you like to mention?'* or *'Tell me about anything else which might be worrying you?'*. Uses appropriate eye contact, body posture, nodding and encouraging gestures. Reflects back verbally and matches patient's language.

- **Negotiates priorities for problems**

Determines jointly with the patient which problems to focus on.

- **Appropriate question style (generally moves from open to closed as interview progresses)**

Avoids interrogative style of interviewing. Listens attentively to patient's response to each question, acknowledges patient's responses. Appropriate use of silence to allow patient to process thoughts and feelings. Allows time to answer.

- **Explores and responds to patient's ideas, concerns and expectations (I.C.E.)**

Uses empathic responses to reflect and legitimate patients concerns. Uses statements *like 'It is understandable that you feel this way about...'/ 'That must have been difficult for you'.* Remains respectful and non-judgmental.

- **Uses language the patient understands**

Matches language and avoids use of unexplained medical jargon.

- **Checks for meaning and understanding, clarifies unclear statements (from both Doctor & Patient perspectives)**

Uses phrases like, *'Can you tell me what you mean by.../ understand about.../ expect to happen...'. And 'Let me just try to understand this a little better/ can I just check with you...?'.*

- **Focuses and re-directs the patient appropriately**

Uses phrases like *'You mentioned X earlier on, can you tell me a little more about that?'* Moves on to using more closed questions.

- **Summarises content, feelings**

Employ's reflection, e.g.*: 'You seem particularly worried by this'* or *'You look upset'.* Uses statements like: *'Can I just go over what we have discussed so far'* or *'let me just go over what we have talked about so that I can be sure I fully understand how this affects you'.*

CLOSING

- **Negotiates a final summary with patient**

Offers a summary statement. Confirms what will happen next.

- **Agrees course of action with patient**

Checks for understanding. Checks emotional state of patient. Asks if patient is OK before he/she leaves patient.

- **Closes interview, says goodbye**

Shakes hands if appropriate.

PATIENT-CENTRED BREAKING BAD NEWS COMMUNICATION SKILLS GUIDE

[This guide is designed to be used as a supplement to the MEDICAL INTERVIEW COMMUNICATION SKILLS GUIDE. The specific skills needed for breaking bad news are to be integrated into those cited in the generic guide].

OPENING - ESTABLISHING RAPPORT

In addition to the Medical Interview Communication Skills Guide:

- **Preparing for breaking the news and checking patient's circumstances**

Think of timing i.e: not in the middle of a busy clinic. Have necessary information at hand. Avoid interruptions. Bring in other staff if appropriate. Is the patient/relative accompanied, do they want another to be included in the consultation? If with an inpatient, find out when visitors are coming.

- **Elicit patients understanding so far**

Ask what has happened to them since their last appointment and what have they been told or construed so far. *'Tell me how you have been since we last met/ What have you been told so far/ Have you any thoughts yourself?'* Do not drag this stage out.

SHARING THE INFORMATION

In addition to the Medical Interview Communication Skills Guide:

- **Step 1: Indicate the serious nature of what you are about to say**

'I do have something to tell you/ I'm afraid it is more serious than we hoped/expected/ I am very sorry to have to tell you/ It's not very good news I'm afraid.'

- **Step 2: Give the information in small chunks and pace carefully**

Allow time for the patient/relative to assimilate each piece of information. Use of silence is important. When anxious or upset we don't listen well; do not follow initial bad news with a vital piece of information. Repeat phrases gently and ask them if they wish you to continue. How much detail do they need at this stage? Respond to patient/relative cues. Do not try to cover everything in first interview.

- **Step 3: Demonstration of empathic responses**

Non-verbal: pitch, tone and pace of voice, eye contact, avoid unnecessary physical barriers ie: large desk. Maintain a calm and open posture, physical contact may be appropriate. Verbal: *'This must be very hard for you/ I know this is a shock.'* Encourage expression of feelings and thoughts. *'Would you like to tell me what you are thinking/feeling now.'* Do not pressurise the patient/relative to divulge anything - respect individual reactions and coping strategies.

SUMMARISING AND CONCLUDING

In addition to the Medical Interview Communication Skills Guide:

- **Check for understanding**

Repeat and clarify. If necessary, encourage further questions. Check for shared meaning. *'Is there anything at all you would like to ask at this stage'.* Offer written materials or other contacts if appropriate.

- **What happens next**

Identify the need for further support. Be clear and simple about immediate follow up. Avoid overloading detail. Be specific about the next step, but use broader terms regarding prognosis at this point. Respond to patient cues. Offer to include family/friends and talk to them with the patient or relative. Give a message of hope and care. Use collaborative terms e.g: *'We will do this together/ We can discuss each stage together*'. Ensure future contact arrangements are agreed. If breaking news of death to a relative ensure help with immediate practical step, bereavement office, nurses etc.

- **Closing the interview**

Having agreed a course of action, allow time for the patient or relative to gather their thoughts before leaving. How are they getting home, do they need a cab ordered, do they need someone to come and get them? [If an inpatient allow privacy]. Reiterate next contact and give telephone numbers etc. [Inform nursing staff about the interview]. Physical touch may be appropriate e.g. hand on the shoulder, gently shake hands.

Appendix 4

Outline – Year's One to Five

Year One

Year one introduces core communication skills and concepts such as developing and maintaining rapport with patients, listening, empathy and question styles. These are universal skills which are culturally applied. For example, communication behaviours to establish rapport in the western world would include a handshake as part of a respectful welcome. This is not the case in all parts of the world, notably with muslim women or people from parts of Indo-Asia. Students need to develop awareness of cultural implications for communication early on in training. Together with core communication skills the key ethical concepts to ensure patient autonomy are also introduced. Individual autonomy, paternalism, confidentiality, consent, beneficence and truth telling provide a basis for ethical practice. Professional duties and guidelines also help learners differentiate between communication behaviours that may be acceptable between friends and relatives in their own social context and the communication behaviours and attitudes that a respectful patient centred practitioner ought to develop. Early patient contact will be provided in both primary care and hospital settings to ensure that students can begin to appreciate how the core concepts and skills learnt can be applied in practice.

Year Two

Year two will revisit core skills and reinforce these through continuing patient contact in hospital and community settings. The development of skills needed to explore patients' problems and the introduction of skills needed when explaining problems and medical care to patients in the context of whole interviews begin to add to the multi layering of skills and communication tasks that are managed within medical interviews.

Year Three

Year three concentrates on developing skills in the clinical setting. At this stage students will begin to integrate the skills needed to carry out core communication tasks, such as explaining and exploring, with higher order tasks such as taking a medical history, using an assessment tool, or performing a physical examination. Skills needed for effective negotiation with patients and relatives are introduced.

Year Four

Year four increases the complexity of clinical communication skills and tasks themselves. The introduction of how to deal with challenging behaviours such as anger or distress in relatives and conflict with other members of a healthcare team allow students to practice the skills and behaviours that will be most useful to them.

Year Five

Challenging and emotional issues having been introduced in year four are then expanded in year five. Breaking bad news, dealing with complaints and interprofessional conflict are examples of specific case based scenarios that students practice. Cross-cultural communication scenarios are revisited and these will include potential problems encountered as a result of differing belief systems from religious or cultural perspectives.

CONTENTS

INTRODUCTION TO TUTOR TRAINING SESSION

FACILITATING ROLE PLAY

This will be a 2-hour session

Register, coffee, tea and group introductions	10 mins
Outline and session objectives	5 mins
Role play as a learning method - advantages and common problems	15 mins
Specific facilitation skills needed for role-play sessions	10 mins
Specific feedback skills	20 mins
Facilitating role play practise and video feedback	55 mins
Debrief, summarise and conclude	5 mins

LEARNING OBJECTIVES

By the end of the session tutors should be able to:

- List advantages and common problems in role play sessions
- Identify ways of dealing with such problems
- Demonstrate facilitation of a role play
- Demonstrate effective feedback skills
- Identify future learning needs.

GUIDELINES FOR ROLE PLAY

It is common for students to feel levels of anxiety and uncertainty about what is going to happen in role play sessions. It is also common for tutors to feel likewise. However, the tutors have a responsibility to welcome the students and develop a rapport with the group. If a supportive trusting atmosphere can be created then this will help and encourage the students to get as much as they personally can out of the sessions.

Some suggestions on how to do this:

If the group is meeting for the first time it is worth spending a few minutes on introductions.

Find out if any of the group have taken part in role play sessions before.

a) They may like to comment on their experience.
b) Find out about their beliefs and views with regard to role play.
c) Describe in simple terms what is going to happen during the session.

Describe role play as an opportunity to practise skills. Role play is not about performing. We use role play to learn and practice communication skills in much the same way as we practice other clinical skills to become more effective or proficient. What are initially perceived as mistakes often turn out to be the most interesting and rich learning opportunities for everyone [including tutors].

Agree on ground rules for the sessions. These might include:

- Confidentiality
- Not laughing *at* others [laughing *with* each other is of course OK]
- Listen to one another
- Don't be afraid to speak

- Be honest
- Respect each other's feelings

If anyone is unsure of worried about anything in sessions then they are encouraged to meet with the tutor to discuss it.

If for any reason students cannot attend or miss a session they are expected to contact the tutor.

EVERYONE IN THE GROUP IS EXPECTED TO ATTEND.

COMMON RESPONSES TO ROLE PLAY

Two of the most common responses from students during role play sessions are:

a) Role play is acting therefore not realistic

It is usually helpful to agree with those who object to role play on the grounds that it is a contrived situation. Any anxieties that they may have ought to be legitimated. After this it is important to reinforce what the *purpose* of role play is.

> *"Role play is useful in helping us to focus and reflect on specific communication issues and processes. It provides an opportunity to practice communication skills which will prove invaluable for you in your contact with patients and others in the future."*

b) Disruptive or displacement behaviour

Joking and intellectualising are common avoidance or displacement behaviours. A skillful facilitator will integrate humour and discussion into the role play. It may be necessary to steer and focus the group back to the purpose of the session so as not to lose sight of what the session is really for. It one of the members of the group is particularly 'difficult' then the facilitator will need to have the skills to manage the challenge in a non-defensive way. Sometimes it helps to ask the rest of the group for their opinion. This allows time for the facilitator to formulate how to answer and behave towards the challenge. It also tends to have the effect of making the problem a shared one and not the facilitator's alone.

INDIVIDUAL 'SAFETY' AND LEARNING NEEDS

A friendly 'safe' atmosphere must be established to ensure that students feel comfortable enough to try out skills in role play. If individuals feel threatened they are unlikely to learn and will not feel confident. They may become defensive or disruptive.

Taking 'time out' is a very important process in role play. This is where students who have 'got stuck' or want to discuss choices for their next move can turn to the group for input. This has a dual function of a learning opportunity and of changing what was initially the student's individual difficulty into a shared group problem.

Feedback is an integral part of role play and needs to be handled carefully. [see guidelines for feedback].

Ensure adequate debriefing at the end of role play or any communication skills exercises. Re-orient the students into their own selves, present time, space and situation.

Do remember that interactive sessions such as these can trigger off personal responses in individuals because of events or experiences in their own lives. Take care when encouraging reluctant individuals to actively participate. Sensitivity is needed with some reluctant participants, it may be that they feel emotionally vulnerable - not just refusing to take part because they think it is rubbish.

PRACTICAL POINTS

Allow enough time to set up the role play. This means:

- checking that everyone knows what is expected of them
- explaining what activity they are going to be doing
- identifying what processes are going to be concentrated on
- clarifying what the context and content of the role play is
- attending to the physical environment - space, seating, observation points
- allowing enough time for feedback

GUIDELINES FOR FACILITATING FEEDBACK

The purpose of feedback is:

- to give the individual information to help them recognise what they have done effectively

- to suggest ways of doing, or thinking about, something differently in order to be more effective in the future

- to help them to identify learning and personal development needs

WHAT & HOW OF FEEDBACK

1) Feedback is not the same as criticism. Feedback is necessary in the processes of teaching and learning. Feedback is a skill and involves informing another of your observations of his or her behaviour. It is not about commenting on an individual's persona or identity. Feedback should be concentrated on what somebody has actually done behaviourally.

2) Allow the student to talk first and offer a self-critique.

3) Focus on the positive first and use descriptive terms.

4) There may be a difference in the intention of an individual and their behaviour. In other words we may intend to achieve something, but our behaviour does not meet the original intention. It is useful to separate behaviour from intention.

5) All feedback is subjective. Always make your comments in the first person. The person receiving it may disagree.

6) Individuals can only take in a few comments at a time. Keep to a few points and don't overload the content.

7) Be specific. Saying "that was good" is not enough. What specifically was good, what did the student do, how did he/she do it? What was the effect of the good communications?

ORDER OF FEEDBACK

LEARNER (Doctor)

↓

ACTOR (Patient)

↓

COLLEAGUES /GROUP

↓

FACILITATOR

(Facilitator may participate to add any outstanding points, checking for learning and summarising.)

CONTENTS

INTRODUCTION

Thank you for volunteering to participate in this training programme. We hope you will enjoy the sessions and we look forward to working with you in the future.

Effective communication in healthcare is tremendously important. Teaching communication skills to medical students is therefore a core subject for medical students here at Guy's, St Thomas' and King's College Medical School. This means that all students practise their communication skills, learn about interviewing patients and are tested on their ability to demonstrate good skills. This is where you come in.

One of the most effective ways for students to practise and have their skills tested is through role play. Throughout the course of these three sessions you will be able to hone your own observation and feedback skills in order to help students learn and examiners to examine. We hope as a result of your efforts, and this course, we will begin to provide a consistent and reliable simulated and standardised patient programme. You will be a vital part of this process.

ELAINE GILL

Communication Skills Unit

WORKSHOP 1

Welcome, registration and tea/coffee [10 mins]

Group introductions [10 mins]

OBJECTIVES [5 mins]

On completion of the session participants will have:

- Taken part in a discussion about the main problems of communication in health care;
- Received information about medical training and the course aims;
- Participated in 3 exercises relating to listening, rapport and empathy skills and question styles;
- Identified factors which may help or hinder listening, empathy and appropriate question styles;
- Had the opportunity to ask questions and have them acknowledged and answered.

IN MAIN GROUP [15 mins]

1. A brief outline of the medical undergraduate course
2. The role of simulated and standardised patients in medical education
3. Why we are running this course
4. Discussion about the main problems of communication in health care

ACTIVITY 1 : Listening [10 mins + 10 mins feedback in main group]

1. Divide into sub groups of 3 or 4
2. Questions for discussion - spend 2 or 3 minutes discussing each of the following questions.
3. Elect a representative to put forward 1 or 2 points on each question for main group discussion
    - Why do we listen and what do we listen to?
    - Is listening a teachable skill?
    - What makes a good listener?

ACTIVITY 2 : Rapport and Empathy [5mins +15mins]

In main group, ask what is rapport and what is empathy?

Break up into pairs and take it in turns to talk and listen. Pick a small problem and discuss it with your partner and then swop roles. Take 5 minutes for each one. Then feedback to each other saying what it felt like to be listened to and what your partner did which encouraged you to go on. You may identify something your partner did which you would like to have been done differently.

ACTIVITY 3 : Question Styles [10 mins + 15 mins]

In main group, ask what are open questions, probing questions, leading questions, closed questions, and when are they appropriate?

Break up into pairs and take it in turns to ask your partner something about themselves. Try and use more than one style of question. [Not too personal, for example, it could be about where they live, work or how they got here today]. Take 5 minutes each and then take 5 minutes to identify styles. Did the question style make any difference to your answers?

IN MAIN GROUP [15 mins]

Questions, summary and conclude

GUIDELINES FOR FEEDBACK

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5) All feedback is subjective. Always make your comments in the first person. The person receiving it may disagree.

6) Individuals can only take in a few comments at a time. Keep to a few points and don't overload the content.

7) Be specific. Saying "that was good" is not enough. What specifically was good, what did the student do, how did he/she do it? What was the effect of the good communications?

ORDER OF FEEDBACK

LEARNER (Doctor)

↓

ACTOR (Patient)

↓

COLLEAGUES / GROUP

↓

FACILITATOR (Facilitator may participate to add any outstanding points, checking for learning and summarising).

WORKSHOP 2

Welcome, registration and tea/coffee [10 mins]

OBJECTIVES [5 mins]

On completion of the session participants will have:

- Taken part in a group discussion about feedback;
- Participated in an exercise to practise giving and receiving feedback;
- Practised standardising a scenario;
- Identify the different skills needed for a simulated scenario and a standardised scenario;
- Had the opportunity to ask questions and them acknowledged and answered;

IN MAIN GROUP [15mins]

What is feedback? Principles and Practise.

Why is it important for you to be able to give effective feedback to students and examiners?

ACTIVITY 1 : Giving and Receiving Feedback [20mins]

Break up into pairs and practise giving and receiving feedback.

Choose a small problem to discuss with your partner. He or she will use listening and empathy skills and may use different question styles. You will then give specific feedback to your partner identifying what went well, what communication skills they used, and anything that may have been done differently. Then switch roles. Take about 5mins to talk about your problem and 3 or 4 minutes to feedback.

ACTIVITY 2: Standardising a Scenario [30 mins]

Work in pairs with a scenario and agree what sort of behaviours you will both demonstrate in response to doctor's different interview styles and communication skills. Your role play needs to be realistic and believable. You may need to compromise some of your own personal responses to meet each other and for you both to feel comfortable about your role.

IN MAIN GROUP - group discussion and identifying different skills needed for the two tasks [15mins]. ***Questions, summary and conclude.*** [10mins]

WORKSHOP 3

Welcome, registration and tea/coffee [10mins]

OBJECTIVES [5mins]

On completion of the session participants will have:

- Watched a short video outlining the principle of OSCE's and participated in discussion and feedback;
- Practised an OSCE role play;
- Had the opportunity to ask questions and have them acknowledged and answered;
- Completed an evaluation form.

IN MAIN GROUP [25mins]

Ask what are OSCE's [objective structured clinical exams] and main principles.

Video and outline of what happens here at GKT . Those of you who have been involved with OSCE's will be invited to share your experiences with the rest of the group.

ACTIVITY: [40 mins]

Role play practise of timed OSCE, using the scenarios standardised in the last session

You will role play a patient x 2 and examiner x 1 in this activity

Questions, summary and conclude [20mins]

Complete evaluation form [15mins]

ON COMPLETION OF THE COURSE

On completion of the course all participants will be given a signed certificate. All participants will receive verbal and written feedback and be invited to participate in further training, student teaching sessions and/or student exams.

IPE Year 1 – Communication Skills Assessment

REFLECTIVE ACCOUNT OF PATIENT INTERVIEW
MARK SHEET

Part 1: Communication skills
Through his/her writing the candidate has:

- Demonstrated understanding of the purpose of the interview [1]
- Reflected on opening phase of interview (introduction, gaining verbal consent, patient confidentiality. Maximum of 3 marks) [1] [2] [3]
- Given examples of communication skills used
  (1 mark for each skill – listening, rapport, empathy, question styles. Maximum of 4 marks) [1] [2] [3] [4]
- Noted the effect communication skills had on the interview process
  (1 mark for each skill – listening, rapport, empathy, question styles. Maximum of 4 marks) [1] [2] [3] [4]
- Reflected on impact of physical surroundings on the interview [1] [2]
- Reflected on thoughts or feelings of self, patient or partner [1] [2] [3]
- Reflected on feedback from partner and/or patient [1] [2]
- Reflected on learning [1] [2]
- Reflected on relevance for future practice [1] [2] [3]

Part 2: Professional skills
Standard of written English to include:

- Reasonable sentence structure [1]
- Evidence of planning and logical development in writing [1] [2]
- Good paragraph layout, underlining, headings, use of graphics / illustrations [1] [2]
- Correct spelling [1]

Part 1 = 24 (min. comp. = 14)
Part 2 = 6 (min. comp. = 4)
Total possible score = 30

CLINICAL COMMUNICATION SKILLS OBJECTIVES - Year 3

Observed medical interview objectives

Clinical attachment _____

	demonstrated	needs practise
• **Opening**		
1 Introduction	☐	☐
2 Attends to privacy and comfort	☐	☐
3 Demonstrates awareness of emotional state of patient	☐	☐
4 Checks with patient their understanding of the purpose of the interview	☐	☐
• **Exploration of the problem and managing time and content**		
5 Surveys problems and concerns	☐	☐
6 Negotiates priorities for problems	☐	☐
7 Uses appropriate questioning styles	☐	☐
8 Explores patients concerns, beliefs and expectations	☐	☐
9 Clarifies and checks for understanding.	☐	☐
10 Uses language the patient understands and checks for understanding	☐	☐
11 Focuses and re-directs the patient appropriately	☐	☐
12 Summarises content and feelings	☐	☐
• **Closing**		
13 Negotiates a final summary with the patient	☐	☐
14 Agrees course of action with the patient	☐	☐
15 Closes interview and checks the patient knows what will happen next.	☐	☐

Student comment:
Tutor comment:

To complete 2nd interview yes☐ no☐

Tutor signed
Student signed

Date

DEALING WITH CRISIS – anger, hostility
Marking Schedule [12 criteria]

Manages key points in interview

- Introduces self and establishes rapport
- Acknowledges individual emotional state [fear, anxiety, anger]
- Demonstrates active listening [tries to find out root cause, appropriate eye contact]
- Demonstrates empathic responses [offers emotional support, validates concerns]
- Remains calm and clear [avoids mirroring or matching individual fear or anger, avoids agitated movements, level tone and pitch of voice]
- Apologises if appropriate [anger/complaint]
- Gives accurate information and/or offers to find out more information
- Summarises and concludes interview.

Avoids following behaviours [anger]

- Patronising [It's not that bad - don't worry about that' etc. Avoids dismissing individuals fear or anger]
- Defensive [Withdrawing in seat, closed body posture. Don't have a go at me, it is not my fault etc.]
- Blaming individual, colleagues or others [fueling conflict or colluding with individual]
- Judgmental statements

DEALING WITH CRISIS – fear, anxiety
Marking Schedule [12 criteria]

Manages key points in interview

- Introduces self and establishes rapport
- Acknowledges individual emotional state [fear, anxiety]
- Demonstrates active listening [appropriate eye contact, open body posture, appropriate question styles]
- Elicits individual concerns [encourages individual to express fears and ask questions]
- Demonstrates empathic responses [offers emotional support, validates concerns]
- Remains calm and clear [tone, pitch and pace of voice, uses simple sentences, repeats and clarifies as necessary]
- Appropriate pacing of information and use of silence.
- Gives accurate information
- Offers /suggests helpful action [referral to other agencies, support at time of procedure, accompanying individual etc.]
- Summarises and concludes interview

Avoids the following behaviours

- Dismissing individuals fears and concerns [don't be silly, there is nothing to worry about etc.]
- Offering inappropriate reassurance [false hope]

Cross cultural communication OSCE marking schedule

[This marking schedule is generic. Therefore not every criteria is necessarily appropriate ie: if the station is English as a second language religious implications may not be relevant. Equally if cross cultural this does not by definition imply difficulty with English. The scenario must be clear. Each criteria must be mutually exclusive. Please check template with comm skills before final print out.]

Manages key points in interview

Establishes [include as appropriate] level of English /or cultural group /or religious implications
Establishes purpose of consultation
Elicits individual ideas
concerns
expectations
Elicits individual beliefs/values
Demonstrates positive behaviour re: individual beliefs [Avoids dismissing beliefs and values]
Offers accurate clinical advice
Uses visual aids [include as appropriate]
Uses alternative words and phrases [avoids repeating words and phrases previously not understood]
Checks for understanding
Acknowledges need for interpreting/or advocacy support
Checks for mutual agreement

Avoids the following behaviours

Patronising.
Judgmental
Coercion

Student Evaluation Form – Year 1

STUDENT EVALUATION FORM 2003-04

Communication in Healthcare Curriculum: Basic Course

Your views and ideas are taken very seriously. To help shape the content and design of future courses please fill in this evaluation form honestly and from your own personal perspective. You will be asked to complete a separate evaluation form for sessions attended within th IPE programme.

Please put the letter, which most matches your view in each box.

a] excellent **b]** very good **c]** good **d]** quite good **e]** not good at all

MBBS Year 1	INTEREST VALUE	LEARNING VALUE
Session 1 Principles of Feedback		
Session 2 Introduction to Role Play		
Session 3 Managing the Medical Interview		

One of the aims of this course is to begin the process of developing core communication skills in medical practice

1] To what extent would you say sessions 1-3 have met this aim. Please tick box

very well	well	quite well	not very well	not well at all

2] Could you identify any personal learning needs with regard to communication skills, which you would like, included at this stage? Please state.

_____

_____

_____

3] Are there any particular aspects of communication in medical practice, which you find interesting, and would like, included at this stage? Please state.

_____

_____

Any other comments?

_____

_____

_____

Thank you for taking the time to complete this evaluation form.

IPE Year 1 – Student Evaluation Form
SESSIONS 1 : 2a : 2b : 3

Your ideas are taken very seriously. To help us shape the design and content of future sessions, please fill in this form honestly and from your own perspective. Rate the following by putting the letter which most matches your view in each box.

** VERY IMPORTANT ** PLEASE indicate your discipline ✓					
Medicine		Midwifery		Physiotherapy	
Nursing		Pharmacy		Dietetics	
Dentistry					

A) excellent B) very good C) good D) not very good E) not good at all

	Interest value	Learning experience	Value for Clinical Practice
IPE Session 1 Introduction (plenary)			
IPE Session 2a Core communication skills			
IPE Session 2b Demonstration interview			
IPE Session 3 Ethics Confidentiality lecture			

Additional comments and suggestions:

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Thank you for taking the time to complete this evaluation form.

IPE Year 1 Student Evaluation Form
SESSION 4 – PATIENT INTERVIEW BRIEFING

Although this session will take place within your own discipline, the learning that surrounds it falls within IPE.

Your ideas are taken very seriously. To help us shape the design and content of future sessions, please fill in this form honestly and from your own perspective. Rate the following by putting the letter which most matches your view in each box.

** VERY IMPORTANT ** PLEASE indicate your discipline ✓					
Medicine		Midwifery		Physiotherapy	
Nursing		Pharmacy		Dietetics	
Dentistry					

A) excellent B) very good C) good D) not very good E) not good at all

	Interest value	Learning experience	Value for Clinical Practice
Patient Interview Briefing			

Additional comments and suggestions:

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Thank you for taking the time to complete this evaluation form.

IPE Year 1 – Student Evaluation Form
SESSION 5 – ETHICS (1)

Your ideas are taken very seriously. To help us shape the design and content of future sessions, please fill in this form honestly and from your own perspective. Rate the following by putting the letter which most matches your view in each box.

** VERY IMPORTANT ** PLEASE indicate your discipline ✓					
Medicine		Midwifery		Physiotherapy	
Nursing		Pharmacy		Dietetics	
Dentistry					

A) excellent B) very good C) good D) not very good E) not good at all

	Interest value	Learning experience	Value for Clinical Practice
IPE Session 5 Ethics 1			

Additional comments and suggestions:

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Thank you for taking the time to complete this evaluation form.

IPE Year 1 – Student Evaluation Form
SESSION 6 – WRITTEN HEALTH INFORMATION

Your ideas are taken very seriously. To help us shape the design and content of future sessions, please fill in this form honestly and from your own perspective. Rate the following by putting the letter which most matches your view in each box.

** VERY IMPORTANT ** PLEASE indicate your discipline ✓					
Medicine		Midwifery		Physiotherapy	
Nursing		Pharmacy		Dietetics	
Dentistry					

A) excellent B) very good C) good D) not very good E) not good at all

	Interest value	Learning experience	Value for Clinical Practice
IPE Session 6 Written Health Information			

Additional comments and suggestions:

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Thank you for taking the time to complete this evaluation form.

IPE Year 1 – Student Evaluation Form
SESSION 7 – ETHICS (2)

Your ideas are taken very seriously. To help us shape the design and content of future sessions, please fill in this form honestly and from your own perspective. Rate the following by putting the letter which most matches your view in each box.

** VERY IMPORTANT ** PLEASE indicate your discipline ✓					
Medicine		Midwifery		Physiotherapy	
Nursing		Pharmacy		Dietetics	
Dentistry					

A) excellent B) very good C) good D) not very good E) not good at all

	Interest value	Learning experience	Value for Clinical Practice
IPE Session 7 Ethics 2			

Additional comments and suggestions:

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Thank you for taking the time to complete this evaluation form.

Student Evaluation Forms – Year 4

STUDENT EVALUATION FORM 2003-04

Communications Skills Symposium: Communicating with the young, elderly and relatives
CHDA Symposium

Your ideas are taken very seriously. To help us shape the design and content of future symposia please fill this form in honestly and from your own personal perspective.

Please rate the following putting the letter which most matches your view in each box.

a] excellent **b]** very good **c]** good **d]** quite good **e]** not good at all

	Interest Value	**Learning Experience**	**Value for Clinical Practice**
Plenary session			
Explaining renal scan scenario			
Explaining asthma scenario			
End of life decision scenario			

Please add any additional comments and suggestions you may have

Thank you for taking the time to complete this form.

STUDENT EVALUATION FORM 2003-04
Communications Skills Symposium: Dealing with Crisis
EMTL Block

Your ideas are taken very seriously. To help us shape the design and content of future symposia please fill this form in honestly and from your own personal perspective.

Please rate the following putting the letter which most matches your view in each box.
a] excellent **b]** very good **c]** good **d]** quite good **e]** not good at all

	Interest Value	**Learning Experience**	**Value for Clinical Practice**
Dealing with Anger and Belligerence			
Dealing with Emotion: Breaking Bad News			
Communicating with a Relative			

Please add any additional comments and suggestions you may have

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Thank you for taking the time to complete this form.

STUDENT EVALUATION FORM 2003-04
Communications Skills: Cross Cultural

Your ideas are taken very seriously. To help us shape the design and content of future symposia please fill this form in honestly and from your own personal perspective.

Please rate the following putting the letter which most matches your view in each box.
a] excellent **b]** very good **c]** good **d]** quite good **e]** not good at all

	Interest Value	Learning Experience	Value for Clinical Practice
Plenary session			
Scenario 1: English as a second language			
Scenario 2: Religious difference			
Scenario 3: Dealing with Complaint			

Please add any additional comments and suggestions you may have

Thank you for taking the time to complete this form.

STUDENT EVALUATION FORM 2003-04
Communications Skills: Breaking Bad News

Your ideas are taken very seriously. To help us shape the design and content of future symposia please fill this form in honestly and from your own personal perspective.

Please rate the following putting the letter which most matches your view in each box.
a] excellent **b]** very good **c]** good **d]** quite good **e]** not good at all

	Interest Value	Learning Experience	Value for Clinical Practice
Plenary session			
Scenario 1: Rheumatoid Arthritis			
Scenario 2: Dealing with an Angry Relative			
Scenario 3: Death of Mother			

Please add any additional comments and suggestions you may have

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Thank you for taking the time to complete this form.

STUDENT EVALUATION FORM 2003-04

Communications Skills: Inter/Intra-Professional Communication

Your ideas are taken very seriously. To help us shape the design and content of future symposia please fill this form in honestly and from your own personal perspective.

Please rate the following putting the letter which most matches your view in each box.

a] excellent **b]** very good **c]** good **d]** quite good **e]** not good at all

	Interest Value	**Learning Experience**	**Value for Clinical Practice**
Plenary session			
Scenario 1:			
Scenario 2:			

Please add any additional comments and suggestions you may have

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Thank you for taking the time to complete this form.

Student Evaluation Form – Simulated Patient

STUDENT EVALUATION FORM 2001-02
Simulated Patients Training Course

Please take a few minutes to complete this short evaluation form. Your views are taken very seriously and help us to improve courses in the future. You will not be identified by name at any stage in the analysis or future publications relating to the course.

Please tick box Professional Role Player ☐ Volunteer patient ☐

P lease rate the following putting the letter which most matches your view in each box.
a] excellent **b]** very good **c]** good **d]** quite good **e]** not good at all

	Interest Value	**Learning Experience**	**Value for Clinical Practice**
Session 1			
Session 2			
Session 3			

Please add any additional comments and suggestions you may have

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Thank you for your time and we look forward to working with you again

Elaine Gill
Guy's, King's and St Thomas' Medical School